Trauma-informed Dance Movement Psychotherapy: Understanding the Therapeutic Process and its Components

Caroline Galon

Department of Performing Arts

Faculty of Arts and Sciences

Edge Hill University

A thesis submitted in partial fulfilment of the requirements for the degree of

Doctor of Philosophy

November 2018

Trauma-informed Dance Movement Psychotherapy: Understanding the therapeutic process and its components

Abstract

The adverse and lasting effects traumatic experiences can have on individuals pose significant challenges to psychotherapeutic treatments. This is due to the profound impact trauma has on the body and mind of survivors which can result in a wide range of posttraumatic symptoms, The unique nature of traumatic memories, and the extent to which they can become engrained, can further complicate treatment considerations. Relevant literature suggests that Dance Movement Psychotherapy (DMP) can be useful for treating survivors of trauma, due to its emphasis on embodiment and creativity that this modality offers. However, research to support this notion is currently limited. Furthermore, not enough is known about how the therapeutic process with survivors of trauma unfolds in the context of DMP. This thesis, therefore, aimed to identify the components of the therapeutic processes used in trauma-informed DMP as a step towards improving understanding of therapeutic practice with this client group.

This thesis used hermeneutic phenomenology as the underlying methodology and epistemological position from which all findings and understandings were derived. It encompassed the following two strands: the first involved semi-structured interviews with practitioners who were experienced in treating survivors of trauma. To ensure a sufficient amount of data were collected, and due to commonalities between the DMP and Body Psychotherapy (BP) modalities with regards to the role of the body in the therapeutic process, participants from both of these professions were interviewed for the first research component. The second strand comprised a heuristic inquiry that utilised embodied and creative practice to synthesise the findings from the first strand, and elucidate further the components of the therapeutic process.

Findings suggest that the therapeutic process for treating trauma comprises of several identifiable therapeutic elements, some of which were grounded in embodiment and creativity and appeared to be specific to DMP. A relationship was found between the concepts of ‘narrative’, ‘trauma-processing’ and ‘ritual’ while the notion of ‘joy’ was identified as

supporting and signifying positive change. Concepts of 'witnessing' and 'resourcing' were also identified. These were perceived by respondents to facilitate and support the therapeutic process with this client group. Applied embodiment and creativity were found to be empowering and seen to facilitate a manageable and paced access to traumatic material. The synthesised results of this thesis are presented as a map of the therapeutic process, and it is suggested that findings may potentially be transferable and useful for other treatment modalities. Overall, the results of this thesis enabled a fuller understanding of the role DMP can play in facilitating therapeutic processes with this client group. Furthermore, the current findings emphasise the contribution that DMP can make to the wider body of knowledge relating with psychotherapeutic treatment approaches to trauma.

Key terms: Psychological Trauma, Dance Movement Psychotherapy, Body Psychotherapy, Embodiment, The Therapeutic Process, Hermeneutic Phenomenology, Heuristic Inquiry, Qualitative Research

Acknowledgements

My first and foremost expressions of gratitude are due to my supervisory team, for the advice and guidance given throughout these last three years. To Prof. Vicky Karkou, who supported with me during this process and in many ways made this thesis possible. To Prof. David Peimer, thank you for a much appreciated on-going support, both as the head of my department as well as an academic supervisor. To Prof. Derek Heim, for being a wonderful teacher with a great sense of humour, and for generously giving your time and energy at precisely those moments when it was most needed. To Prof. Steve Davismoon, for the kindest HoD I worked with and whose support enabled the performance of my heuristic inquiry to come into being.

To the staff of the Department of Performing Arts, thank you for the support, teaching and learning opportunities, the inspiration and the friendships.

To the graduate school, thank you for all the training and for encouraging me to become an independent, confident researcher. To Dr. Leon Culbertson, thank you for being the first who believed I could do it. To Dr. Nikki Craske, thank you for your availability, consistency, guidance and council.

To Elida Cena, it was a privilege to share this process with you.

My heartfelt gratitude goes to my 5 Rhythms' family who were always there, holding space for me to get out of my head and drop into my body. Being able to dance my way through this research has enriched it beyond what words can express.

To Joel Gytenbeek, my witness, I could not have made it through the therapeutic process without you. To Naledi Withers, thank you for lending your voice to mine so that my story could be heard. To Dawn Summerlin, who understood and brought her creativity and skill together to make me the perfect costume.

Last, but always first, my family: To my sister Elior, who is always a phone call away, and to my parents, Batia and Yossi, for the inspiration, love, strength and infinite support. And for marking the path towards growth so I can walk in it too.

Thank you.

Table of Contents

List of Tables

List of Figures

1 Introduction

1.1 Introduction

Due to the range and depth of human responses to psychological trauma, it is considered one of the most complex mental-health issues in the world today (van der Kolk, 2003, 2015). The impact of trauma can be severe whereby it may come to dominate the survivor's consciousness and negatively alter their perception of themselves and of reality (Siegel, 2003). Because of this, treatment is difficult and careful consideration is essential. This thesis will look at the contribution that Dance Movement Psychotherapy (DMP) can make to the field of trauma studies, by identifying the therapeutic means that are used to treat this client population.

In this introductory chapter, I first present the background of this thesis and context from which I conducted the research, to clarify my position as a researcher. I then outline the rationale for researching this specific topic from theoretical and clinical perspective, while presenting and defining the terms that I use throughout the thesis. The questions that were used to guide the investigation follows, along with a brief introduction of the chosen methodology as well as the reasoning that guided me to utilise a qualitative and phenomenological framework I conclude this chapter with a succinct overview of the thesis structure.

1.2 The researcher's position and personal context

To make transparent my position as a researcher and my underlying attitude towards the research topic, I will briefly outline my personal context and the perspective from which I approached this thesis. My motivation for conducting this thesis is rooted in my experience as a qualified Dance Movement Psychotherapist, as well as my interest in clinical treatment of psychological trauma (trauma). I present my professional training here as possibly influencing my perception of embodied and creative psychotherapeutic means as highly beneficial, and in

particular in relation to treatment of trauma. It is also probable that my clinical background as a Dance Movement Psychotherapist led me to perceive non-verbal methods of treatment as useful both as stand-alone interventions as well as in correlation with verbal means. My interest in trauma work has been ongoing since I began my professional training. For example, as part of my MSc I investigated my own experience as a novice DMP practitioner while undertaking clinical work with survivors of trauma, specifically looking at the embodied and emotional impact such work has had on me as the therapist. The main findings from my MSc research indicated that embodied therapy with survivors of trauma can have an adverse impact on an inexperienced therapist (Galon, 2012 unpublished). Furthermore, I discovered there was but little that DMP literature could offer to have enabled novice practitioners (such as I was then) to better manage clinical work with clients survivors of trauma (Galon, 2012 unpublished).

From a more personal perspective, I am a survivor of trauma as well as offspring of survivors of trauma and my parents are, in turn, offspring of survivors of traumatic experiences. Therefore, my interest in trauma treatment is personal and professional, embodied and theoretical, empirical, and academic as well as practical. I do not suggest that my experience better qualifies me to research this topic than someone who has had no experience of trauma, or the opposite. However, my personal experience and background are likely to have informed my perspective and understanding of the meaning that both trauma and its treatment can have. This is offered here to make the process transparent and to enable the reader to better understand the rationale and subsequent conclusions presented in this thesis. In the context of qualitative methodology, transparency is seen to further the trustworthiness of the researcher and, as a consequence, of the research (Lincoln and Guba, 1985).

1.3 Rationale for the research

Trauma is considered as a complex mental health problem which evokes diverse responses from different people and has long-term negative impact (van der Kolk 2015). The effects of trauma are often extreme and believed to result out of the experience of threat which consequently influences and altering one's perception of the world (Siegel 2003). The impact of trauma is often regarded as posttraumatic responses which can range from being short-term to permanent, depending on individual circumstances. Current understanding of trauma and its effects is

embedded in the notion that traumatic memories have a sensory/somatic quality that presents particular challenges to treatment. Traumatic memories are understood to remain unchanged over time and manifest in survivors' daily lives through various distressing symptoms (Peres *et al*, 2008). Furthermore, in clinical practice it can initially be difficult to assess the extent to which a person was affected by traumatic experiences as clients may not be aware of the full impact themselves. This as a factor can add complexity to evaluating treatment outcomes

Current available methods for treating survivors of trauma vary greatly and while some treatments are more thoroughly researched than others, no conclusive evidence appears to have emerged to indicate that certain modalities or approaches should be prioritised over others (Gerger *et al*, 2014). Foa et al. (2009) highlighted research bias as a possible explanation as to why some treatment methods for trauma have been better investigated to date than others. For example, prolonged exposure therapy was suggested to be more compatible than hypnosis with quantitative research methods such as randomised controlled trial (Foa *et al*, 2009), which tend to dominate clinically relevant research. According to this, it can be suggested that a limited amount of evidence underpinning a given method does not necessarily signify a lack of efficacy but may be a result of a hierarchy of research and funding priorities. Be that as it may, current trends in trauma studies highlight the usefulness of CBT-oriented methods which primarily utilise verbal and cognitive means for treatment of survivors (Foa *et al*, 2009; Hopper, 2017). However, it has been argued that a link exists between the unique quality of traumatic memories and the notion of trauma being stored in an embodied form, thus having a strong sensory-emotional component (van der Kolk 2015). As a result, I posit that treatment needs to account for all aspects of the experience of trauma, including its embodiment. It appears that untreated traumatic experience may lead to development of dissociation and avoidance as a coping mechanism, both important yet problematic strategies, used for self-preservation and survival (Hopper, 2017). I suggest here that this engrained complexity may be addressed through DMP as well as through verbal means to uncover and treat the different aspects of the effects trauma may have.

DMP is a somatically oriented form of psychotherapy aimed at facilitating integration and growth through the use of creative movement exploration, and verbal and non-verbal means (Levy, 2005; Karkou & Sanderson, 2006). Research literature in DMP suggests that this can be

a useful modality for the treatment of trauma survivors due to the emphasis that is placed on a creative and non-verbal approach to psychotherapy (Gray, 2001; Koch & Weidinger-von der Recke, 2009; Dieterich-Hartwell, 2017). Despite claims pertaining to the benefits of DMP for trauma treatment, current evidence is still regarded as limited in scope (Meekums, 2010; Dieterich-Hartwell, 2017). Furthermore, Baum (2009) highlighted the lack of a trauma-specific DMP framework, and while the literature points to a degree of diversity in interventions and trauma specification, it is simultaneously regarded as insufficient to have a substantial impact on the wider field of trauma studies (Johnson, Lahad & Gray, 2009). What is often used as an argument in favour of DMP are the therapeutic effects that are achieved through the use of symbolism, metaphor and non-verbal communication, which in turn enables clients' self-expression and psychological integration (Karkou & Sanderson, 2006). However, in this thesis I argue that these notions are neither specific enough to endorse DMP as useful for trauma nor to incorporate use of creative and embodied methods in public health policies. While more recent studies have attempted to link neuroscience evidence with the impact that engaging with DMP may have on the brain (Pierce, 2014; Grey 2017), little evidence exists that can validate the use of DMP for treating trauma. Therefore, I suggest here that more fundamental research is needed to (i) map the processes that are used in clinical practice and (ii) identify creative and embodied therapeutic elements that are relevant to this client population. I therefore propose that an investigation into the means by which DMP is used to treat trauma may be a useful point of departure to begin to fill this gap in the literature. A potential source of support for this may be the affiliated field of Body Psychotherapy (BP).

BP is a growing body of clinical practice that is anchored in the notion that the body and the mind are interrelated (Payne *et al*, 2016). As in DMP, BP literature advocates that mental-health issues can be addressed through body work and by increasing the awareness of clients of the mechanism of their own physicality (Goodrich-Dunn & Greene, 2001; Payne *et al*., 2016). In relation to trauma work, BP literature consists of some innovative and pioneering practices (Rothschilde, 2000; Levine, 2010; Ogden, Minton & Pain, 2006; Ogden & Fisher, 2014). As a modality to treat trauma, elements drawing upon BP principles, such as body scans and the use of sensations and breath, were found to have been integrated with other evidence-based methods: for example, CBT interventions (Foa *et al*, 2009; Leenarts *et al*, 2013). As current

evidence indicates that BP may be a useful method for the treatment of trauma, I have chosen to incorporate available knowledge from this method into this DMP-focused thesis. Due to the richness of trauma-informed BP literature and the similar emphasis on the body as central to the treatment, I deemed it useful to draw on this body of knowledge to support this research. Furthermore, due to the relevant trauma-informed DMP literature having been perceived as limited, I chose to incorporate knowledge from BP to ensure sufficient data were collected for this thesis. I intended to communicate the findings in a transferable way to ensure these may be utilised to inform BP practice, and without losing sight of the focus of this thesis, e.g. trauma-informed DMP.

In short, my interest in this thesis is to identify and better understand the therapeutic process as seen with survivors of trauma and from a DMP perspective, an area that is largely unexplored within current research literature. The next step was attempting to define and conceptualise the therapeutic process into a researchable topic, which led me to the conclusion that it was a non-tangible concept and dependent on multiple variables. For the purpose of this thesis, the therapeutic process as a term refers to the process clients undergo during the course of the therapy and is used here exclusively in the context of trauma-informed practice. Following from that, I argue here that the principles underpinning DMP treatment approaches need to be better characterised and understood, and with the potential aid of relevant and available knowledge from BP, before outcome-focused research can be effectively carried out. Finally, I suggest that researching trauma-informed DMP treatment by investigating the meaning of the therapeutic process, as well as conceptualising it as made out of separate components, is a novel and innovative approach to examine this topic.

1.4 Background

1.4.1 The phenomena of psychological trauma and its impact

Events such as violence, assaults, abuse, accidents and disasters are all too common in human society and have the potential to cause psychological trauma to those that survive them. For the purpose of this thesis, the term trauma refers to the psychological damage occurring when a person experiences (or witnesses) an event or events that are perceived to represent a substantial

threat (van der Kolk, 2015). Exposure to overwhelming events can have both acute and long-term negative effects; research indicates that approximately 15 percent of survivors will develop a full-scale posttraumatic stress disorder (PTSD), while many others will suffer from chronic posttraumatic symptoms (Siegel & Solomon, 2003). According to Caruth (1995), it is not necessarily the distressing nature of an event that makes it traumatic; rather, it may be its perception as a threat - a primal experience of danger - which can then result in psychological damage to the survivor. Following from that, I suggest here that defining an event as traumatic is dependent on individual perception and as such makes the task of defining events as traumatic highly complex.

Siegel (2003) suggests that exposure to an event perceived as traumatic can be associated with a large number of related mental-health disorders, including depression, anxiety, self-harming behaviour, substance misuse, eating disorders and sleep disturbances. While these symptoms are recognised as mental-health issues in their own right, they are also known to often be rooted in the experience of singular or repeated traumatic events (van der Kolk, Weisaeth & van der Hart, 2007; Hammersley *et al,* 2016). Posttraumatic effect can also manifest, for example, in the survivor's reduced capacity to cope appropriately with difficult situations, as their experience of threat becomes dominant in their everyday lives (van der Kolk, 2003, Ogden & Minton, 2000; Levine, 2010). Co-morbidity of different symptoms can also be seen with this client group and may impact treatment, particularly when the link to trauma is not explicit due to clients' possible lack of disclosure of the trauma (Herman, 1994).

Research indicates that traumatic memories have a unique quality that makes them dissimilar to other memories (Ogden, 2006; Peres *et al*, 2008). Traumatic memories stay omnipresent in the survivor's daily existence and can re-surface spontaneously or in response to specific stimuli, and may result in severe psychological and physiological distress (Rothschild, 2000; van der Kolk, 2006; Lopez, 2011). However, it is possible for survivors to carry the traces of the trauma in their psychological and physical make-up without having a conscious or clear recollection of the trauma-inducing event or events (van der Kolk, 2015). Due to the impact trauma can have on the recall system, memories and current experiences may merge and become encapsulated and unchanged in the survivor's psyche, then re-surface intrusively in the survivor's daily life (Caruth, 1995; Ogden & Minton, 2000; Foa, 2006).

According to Ogden et al. (2006), the overwhelming nature of trauma can result in a fragmented experience where the emotional and mental components become detached from one another. Siegel (2003) further suggests that during traumatic events, a psychological split occurs between the cognitive, the emotional and the sensory parts of the person, and this split prevents the integration of the experience with other life events. Similarly, van der Kolk (2015) asserted that fragments of experience can become dissociated from the narrative recollection of the actual experience. These information fragments disintegrate from the experience, are seen to become suppressed and encrypted in the survivor's unconscious, and subsequently resurface as triggers (van der Kolk, 2015). In other words, the overwhelming impact of trauma may be of such magnitude that the capacity to integrate the experience into conscious understanding is impaired (Laub, 2013). A key question for treatment therefore concerns the means through which the fragmented pieces of memory and experience can be processed and integrated.

In this thesis I use the term trauma effect as representing the negative alteration in the perception of self and of reality that may happen in individuals as result of traumatic events. Following the notion that trauma is a subjective experience I propose that trauma effect is likewise an individually determined phenomenon. According to van der Kolk (2015), the impact of trauma may take the form of any of a wide range of somatic, cognitive, emotional, social and behavioural changes which then restrict and hinder the survivors in their day-to-day lives. The term posttraumatic symptoms, as used here, refer to those predefined pathological specifications that are understood as potentially resulting out of traumatic experiences: for example, depression, anxiety and dissociative identity disorder, to name but a few (DSM – V 2013).

1.4.2 Evidence-based trauma treatments

Current trauma treatment research tends to focus on Cognitive Behavioural Therapies (CBT) for trauma, and Eye Movement Desensitization and Reprocessing (EMDR) (Bradley *et al*, 2005; Cusack *et al*, 2016). CBT methods draw on social-cognitive theories with a focus on the impact trauma has on the person's belief system (Cahill *et al*, 2009). According to Foa et al. (2006) prolonged and controlled exposure to the trauma experience allows for re-conditioning of clients' negatively altered world views. EMDR, on the other hand, is a treatment method that utilises rapid eye movements to desensitise and process traumatic memories. This treatment was

specifically designed for trauma treatment and the evidence attests its efficacy (Spates *et al*, 2009). EMDR is founded upon adaptive information processing theory, which highlights the need to complete the processing of physiological information experienced during the traumatic event or events that remain unassimilated (Shapiro & Maxfield, 2002). This theory regards the unprocessed trauma memories of thoughts, images and sensations as the foundation of dysfunctional responses (Shapiro & Maxfield, 2002). These methods are currently well-established due to their evidenced efficacy and are considered as the leading methods for trauma treatment.

According to Cusack et al. (2016), evidence of efficacy is concerned mainly with CBT-based exposure therapies as well as EMDR. Following a comprehensive meta-synthesis Cusack and colleagues (2016) found that head-to-head evidence was insufficient to determine these treatments' comparative effectiveness, while data regarding participants' adverse history were lacking in most studies reviewed. This suggests that CBT and EMDR are indeed effective for trauma but not necessarily better than the other methods aimed at this client group. Therefore, there remains much scope for further investigation into different approaches for trauma-treatment.

1.4.3 Trauma-informed DMP

As a form of psychotherapy, DMP is informed by traditional psychotherapeutic approaches, the main ones being psychodynamic, humanistic and developmental (Karkou & Sanderson, 2006). The body and movement are considered to be at the heart of DMP, and are used as means for self-exploration and to enable self-expression (Levy, 2005). For example, creative movement/dance exploration may be employed to further emotional and cognitive elucidation of an explored theme in a process through which clients may better integrate different parts of themselves (Chodorow, 1991; Boas, 2006). Thus, DMP supports the idea of the body-mind connection from a psychological/psychotherapeutic perspective. The European Association of Dance Movement Therapy (www.eadmt.com) recognises the use of creative movement to support emotional, physical, cognitive, social and spiritual integration and emphasises the therapeutic relationship between the therapist and the client as a central instrument in the therapeutic process.

Central to DMP is the concept of non-verbal communication (Levi, 1995; Karkou & Sanderson, 2006), which includes notions of interpersonal flow of tacit and embodied information, e.g. when we know something without it being verbally articulated (Panhofer & Payne, 2011). Movement exploration (Bernstein, 1979) and non-judgmental acceptance (Adler 2002) are used in DMP to enable trust and freedom in the therapeutic relationship. Movement symbolism, or movement as a metaphor (Chodorow, 2007), is another aspect of the approach whereby the movement is used to access unconscious material, and the movement is regarded as a metaphor that represent a theme from the client's life (for example, a relationship). DMP is practiced in both special education and in mainstream schools, in hospitals as well as in private practice, and is used with a variety of client populations such as those with dementia, depression, PTSD etc. (Karkou & Sanderson, 2006).

The strength of DMP for trauma is seen in the use of embodied and creative means with psychotherapeutic orientation, which enables survivors to access traumatic material non-directly (Levy, 2005; MacDonald, 2006). These methods allow for a gradual processing of traumatic material, as the use of the body and creative movement facilitates indirect access to traumatic memories and reduces the risk of the process becoming overwhelming (Johnson, 2009). Meekums (2000) suggests that the combination of verbal, non-verbal, artistic and creative means is useful in integrating the different parts of the self, which were previously fragmented by the trauma. In DMP, the use of the creative process is utilised for meaning-making and the integration of complex experiences, and is regarded as particularly useful when the non-verbal exploration is combined with verbal articulation (Karkou & Sanderson, 2006). The use of non-verbal and embodied exploration methods in DMP was suggested to enable clients to access and process unconscious material in a less challenging manner than the verbal exploration that is often required in talking therapies (Meekums, 2000; Koch, 2008; Dieterich-Hartwell, 2017). According to DMP literature, the use of non-verbal explorations supported clients to increase their capacity to articulate the trauma narrative in an embodied form, which then resulted in enhanced integration and wellbeing (Helmich, 2009; Dieterich-Hartwell, 2017).

Overall, the literature highlights a number of benefits of DMP for clients with diverse traumatic histories (Baum, 2009; Bernstein, 1995; Harris, 2009; Helmich, 2009; Levy, 2005; MacDonald, 2006; Dieterich-Hartwell, 2017). An examination of the different modalities and techniques

described in the literature shows much diversity of frameworks and conceptualisations of trauma. Meekums (2000), for example, advocates the use of creativity as a foundation and a guiding principle in group therapy with women survivors of childhood sexual abuse. Herbert (2006), on the other hand, used an integrative approach to develop a treatment framework based on different disciplines, including Dance Therapy, CBT, Clinical Psychology and Gestalt therapy. Illustrating a yet further shift in emphasis, Baum (2009) theorises trans-generational trauma and highlights the role of the body as the keeper of the trauma through the generations. Finally, Harris' approach (2009) emphasises the use of ritual and its embodiment in the context of his work with former boy-soldiers in Sierra Leone. The above are a few examples brought here to highlight the disparity found in current DMP literature in relation to clinical work that was used for treating trauma. While each example contributes to the growing body of work that describes embodied and creative methods used in trauma-informed DMP, little cohesion and pattern can be identified to link given interventions with specific traumas and/or client specification.

In short, it is possible to suggest that DMP literature supports the notion that creative and embodied approaches to treatment are at least equally helpful for trauma treatment than are some of the evidence-based treatments. However, it was argued that most of the existing literature lacks robust evidence to support this claim (Harvey, 2009; Meekums, 2010). I posit that trauma-informed DMP literature often showed a tendency for anecdotal reporting of research and/or clinical work, as well as diverse theoretical foundation. Both these factors, I suggest, undermine clinical cohesion in the sense that, following the existing body of work, it is difficult to establish a theoretical foundation for a trauma-informed DMP framework. This thesis proposes that while valuable research has been carried out in the past that examined different approaches used in DMP for trauma, evidence is, as yet, insufficient and too inconsistent to establish a common foundation. I suggest here that therapeutic processes are in fact the overall sum of various therapeutic elements that are currently not theorised and linked together in a pattern of cause and effect. This thesis, therefore, aims to map in greater detail the therapeutic components which are used in DMP to treat survivors of trauma in order to contribute to furthering current knowledge, improving clinical practice and informing future research.

1.4.4 Trauma-informed BP

Focusing on bodily dimensions in psychotherapy stems from the idea that the psyche and the body are integrated and influence each other; therefore, a person's experiences will have an embodied component (Eiden, 2009; Payne *et al*, 2016). Reich (1942, 1949) introduced the idea that muscular tension is associated with emotional activity and stress, and suggested that work that focuses of the former will have impact the latter. Currently, BP is an evolving school of clinical practice which uses a variety of approaches and frameworks, all of which share the notion that the body and the mind are interconnected and that mental-health issues can be addressed through the utilisation of body work (Goodrich-Dunn & Greene 2001; Payne *et al*., 2016). Following this, psychological difficulties are, for example, often considered in BP as expressed in muscular tension, while release of this bodily tension is believed to result in emotional and cognitive release (Hartley, 2009; Westland, 2015). This is often achieved through body-based exercises and/or focus on physical sensations. This approach is somewhat different from DMP as, in the latter, often creative movement exploration and improvisation would be utilised to facilitate whatever release was deemed appropriate and achievable.

BP is considered particularly useful for the treatment of trauma and in recent years a number of trauma-focused frameworks have been developed in response to growing recognition of the contribution this modality may have to this client population (Levine, 2010; Ogden, Minton & Pain, 2006; Rothschild, 2000). Body-based interventions such as the exploration of sensations, grounding and breathing exercises are used to increase body awareness and unlock suppressed trauma-related emotions (Levine, 2010; Ogden, Minton & Pain, 2006; Rothschild, 2000; Eiden, 2009). However, while BP has been accepted as a method that is potentially useful for trauma treatment, it is often used in combination with other frameworks (Leenarts *et al*, 2013). Currently, research that attests the value of BP for treatment of trauma is limited and by including this modality here, I am hoping to enable greater understanding of the value of embodied methods for the treatment of trauma. This in turn may to a degree serve to enhance the knowledge of trauma-informed BP.

1.5 Research aims and questions

With the above in mind, the overall research aim of this thesis is to investigate trauma-informed therapeutic processes and their components in the context of DMP practice. I argue here that the therapeutic process is best understood as the overall sum of different therapeutic elements that together, somehow, may enable survivors of trauma to achieve relative recovery. It is precisely this 'somehow' that this thesis set out to elucidate with a view to providing greater clinical clarity. Once identified, the components can be assessed, evaluated and tested for efficacy through qualitative and quantitative means in order to further develop clinical DMP practice with this client population. Due to the recognised similarities between DMP and BP, and in light of the limited knowledge base, I made the choice to include BP-oriented knowledge to support data collection. However, the focus of this thesis remained on DMP as the exit and ending points of the investigation, as the research question and sub-questions suggest and in line with the principle of the hermeneutic circle:

1. How is psychological trauma being treated in DMP?

1.1 What is currently known about the therapeutic methods used for treating trauma in DMP and BP literature?

1.2 Based on their clinical experience, how do DMP and BP therapists understand and conceptualise the therapeutic process for trauma and its components?

1.3 How can research findings and insight be synthesised and translated into practice-based DMP?

1.6 Methodology

Hermeneutic phenomenology is the methodology I chose to use in order to investigate the therapeutic process in the context of trauma-informed practice. In applied phenomenology the

individual and lived experiences of people are used as the primary source of data through which a phenomenon can be accessed (Smith, 2011). The term 'lived experience' is used to differentiate the representation of an experience as captured through data collection methods from the original experience that occurred in the past (van Manan, 2016). It was suggested that a study of experiences is in fact a study of the individual representations of them, which is always anchored in the personal context of a particular person and their meaning-making processes (Smith, Flowers & Larkin, 2009; Etherington, 2016). In this thesis, I refer to the term lived experiences to signify that the primary source of data utilised in the study was anchored and drawn from the participants' experiences and representative of their embodied knowledge. In addition, I chose to use this term to emphasise my qualitative and phenomenological position that regards personal experiences as a valuable source of data, precisely because it represents personal processes of meaning-making and understandings. Furthermore, I see this term as also suggesting the embodied component that is inevitable when living in the world (Merleau-Ponty, 1962) and as such is relevant and appropriate for DMP-oriented research.

Hermeneutic phenomenology as a methodology highlights the use of interpretation as a main epistemological tool as well as the hermeneutic circle as a conceptual principle used for investigation (Gadamer, 1977; Smith, Flowers & Larkin, 2009; Smith, 2011). The hermeneutic circle is a philosophical notion of meaning-making by which the meaning of a phenomenon is made known through the study of its parts, while the understanding of the parts is gained through knowledge of the phenomenon as a whole, carried out in a repeated and cyclical manner (Gadamer, 1977). Knowledge, from this perspective, is gained through utilising one's own interpretation throughout the entire research process from formulating the research questions, through data collection and analysis stages to the interpretation of the research findings. This is seen as epistemologically inevitable in any type of investigation and founded on Heidegger's (1978) notion that the manifestation of given phenomena is inextricably linked with the observer's interpretation of it. In other words, a phenomenon qualifies as such as a result of the observer's suggestion of its importance, which in turn is a product of their interpretation and meaning-making mechanism. In addition, applied hermeneutic phenomenology often focuses upon, or makes use of, the ideographic nature of the meaning-making process (Smith, Flowers & Larkin, 2009). This ontological position that multiple realities exist based on individuals'

different perspectives, is in line with the theoretical underpinnings of the psychotherapeutic professions that tend to view each client as an individual. DMP literature often highlights the individual needs of clients and the importance of taking those into account throughout the course of the therapy. I suggest that this notion mirrors ideas underpinning Rogers' (1961) developments of person-centred therapy, and which are also found in DMP regardless of theoretical orientation. Considering the above, I deemed it fitting for this thesis to use a methodology that values individual, personal and embodied perspectives, which is in line with therapeutic and conceptual approaches identified in DMP.

1.6.1 Research design

With the above in mind, and to conduct this research and answer the research questions satisfactorily, the research was designed as following two strands to collect and analyse relevant data, and consolidate subsequent findings. A literature review was also conducted to understand the current state of the art and answer the first research question. As a consequence of the rationale underpinning this research, and with the aim to conduct a thorough and an in-depth investigation, data were gathered and analysed from two perspectives - the first including a DMP and BP practitioners' lived experiences and the second drawing from my own embodied history and practice. It is important to note that the methods used for data collection, analysis and dissemination were in line with the hermeneutic phenomenology stance to maintain methodological consistency.

The initial part of this thesis involved a critical review of available trauma-informed, DMP and BP literature done in order to identify which treatment approaches are used with survivors of trauma. The literature was reviewed to gain a better understanding of the current state of the art and to identify existing gaps. The first strand of research utilised semi-structured interviews to gather the participating therapists' lived experiences, and Interpretive Phenomenological Analysis (IPA) was used to analyse the data obtained. I chose IPA as an established and thorough approach that is closely aligned with hermeneutic phenomenology and which enabled me to carry out an in-depth and detailed analysis of the interviews (Smith, Flowers & Larkin, 2009). In the second strand I utilised heuristic inquiry to investigate my own understanding and interpretation of the topic from an embodied and practice-based DMP perspective. Heuristic

inquiry, similarly to IPA, in founded on phenomenological philosophy and asserts subjective perspective as its guiding epistemology (Moustakas, 1990). Furthermore, heuristic inquiry as a method provided me with a framework though which I was able to focus on my meaning-making and interpretation mechanism, and from an embodied and creative perspective. Thus, I was able to come as close as possible to replicate a trauma-informed, DMP therapeutic process, and to further elucidate my embodied understanding of the therapeutic components identified in the interviews. This last strand was also used better enable myself to understand how the findings help to answer the research aims. This last strand of research helped me to conceptually elucidate potential core components that may support therapeutic processes used in DMP for the treatment of trauma.

1.7 Thesis structure

Each of the chapters in this thesis address questions around the creative-embodied therapeutic process for the treatment of trauma, and serves to explicate the narrative of the research. Grounded in the hermeneutic stance this narrative is subjective by definition, and much detail is given in each chapter to make the meaning-making and interpretation processes transparent and dependable (Lincoln & Guba, 1985).

In Chapter 1 I introduce the research, identify the research problem and locate the topic within the broader clinical contexts of trauma studies, BP, the creative arts therapies and DMP. This chapter provides an overview of the research and its rationale from a theoretical and methodological perspective. I also highlight in this chapter the gap in the literature which I identified and was the exit point of this thesis

Chapter 2 is a review of relevant theoretical perspectives of possible causes and effect of psychological trauma. This chapter establishes the clinical underpinning of this research and argues for positioning the concept of traumatic experience within phenomenological framing. Furthermore, this chapter is a critical review of DMP- and BP-relevant literature which discusses the various approaches and treatment considerations of clinical work with survivors of trauma. Gaps in DMP and BP literature for trauma are highlighted and examined as rationale for this thesis, and contextualised within the broader body of work from the creative arts therapies.

Chapter 3 concerns the methodological considerations, aims and objectives used to carry out this research. Hermeneutic phenomenology is first discussed from a philosophical perspective to highlight my ontological, epistemological and reflexive stance. This chapter continues with a discussion of the research application of the hermeneutic approach and the conscious use of the researcher's reflexivity, interpretation and meaning-making mechanism to produce new knowledge. The concept of the hermeneutic circle is discussed as the epistemological principle that underpins the analysis of data conducted for this thesis. An overview then follows of the two separate and interlinked strands of research that were used for this investigation and the supporting methods are described with references to hermeneutic phenomenology as the overarching methodology. Finally, ethical considerations are presented along with the measures taken to ensure the credibility and quality of the research.

Chapters 4, 5 and 6 outline the findings elucidated from the empirical research which was conducted through semi-structured interviews with DMP and BP with expertise in treating survivors of trauma. Throughout these chapters interview extracts are presented and followed by my interpretation of their possible meanings and in regards to their relevance to the topic of this thesis, i.e. use of embodied and creative methods in therapeutic processes for treatment of trauma.

Chapter 4 collates the discussions made by the participants regarding their self-perception as therapists as well as the part they play in the therapeutic process. In this chapter I present the role of the therapist as elucidated through the participants' reflections of their practice and lived experiences of it. This chapter highlights the different elements the participants suggested to be helpful in the therapist's conduct, self-management and approach to trauma-informed therapeutic processes that utilised embodied and creative methods.

Chapter 5 establishes the understanding of the participants regarding their clients and the challenges faced by them while engaging with clinical practice. This chapter also includes the knowledge expressed by the participants of trauma, its effects and implications in the context of DMP and BP. In this chapter I highlight the factors that the participants suggested as potentially hindering the therapeutic process –, for example negative life-style – and those factors that can support it, such as clients' ownership of the process.

In Chapter 6 I focused on the constructs of the treatment as discussed by the participants, and highlighted the therapeutic factors and elements they suggested to have helped to facilitate DMP and BP for the treatment of trauma. I felt that the findings presented in this chapter elucidated the practical and applicable components of the process, which have set the foundation for the second research strand used for this thesis, the heuristic inquiry.

Chapter 7 concerns the heuristic inquiry that was utilised to bridge theory and practice through means of creative and embodied research methods. In this chapter I discuss my experience of using creative research to synthesise my findings, to enhance clarity of dissemination and ground it in embodied practice. The heuristic strand functioned as a filter through which the findings I identified in the previous chapters were further clustered and consolidated. In this chapter my narrative of the embodied inquiry/examination of the process in practice is presented and leads to the culmination of the inquiry as an immersive performance. I suggested here that the performance is watched first before the chapter is read (see Appendix A). Finally, in this chapter I discuss the embodied meaning of the main findings, i.e. the identified components of the therapeutic process in trauma-informed DMP.

Chapter 8 concludes this thesis by offering an overview of the main findings which I then discuss in relation to the relevant literature. The implications of the findings are contextualised in relation to DMP and I highlight the potential of this modality to treatment of trauma, as stemming from this research. I conclude this chapter by presenting the main clinical and methodological contributions to current knowledge resulting from this thesis, the limitations of the research and finally a recommendation for further investigation that may enhance the understanding of trauma-informed DMP.

2 Literature Review

2.1 Introduction

This chapter is organised in two parts. Psychological trauma as a pathological condition is first discussed conceptually. The first part presents and discusses psychological trauma as a pathological condition. In this part, established treatment methods for trauma are also referred to, such as CBT and EMDR. This is followed by an introduction to the creative arts therapies as other forms of treatment for trauma that utilise creative and embodied approaches, namely music, drama and art therapy. In the second part, trauma-informed practice is reviewed as stemming from DMP and BP literature. Criteria for the selection of sources are listed. The review considers different types of evidence and includes research papers, theoretical frameworks and varied accounts of clinical work; publications from peer-reviewed journals as well as books are also referred to. The review aims to highlight practice-based interventions and treatment approaches while identifying gaps in the literature. This allows for the contribution to knowledge achieved in this thesis to be contextualised appropriately.

2.1.1 Search strategy

To carry out this review, an online literature search was conducted using the following electronic databases: CINAHL, Medline, PsycINFO, Sciencedirect and Google Scholar. The key words used for the search included variations and combinations of the following: Movement Psychotherapy; Body Psychotherapy; psychological trauma; posttraumatic symptoms; embodiment; creativity; and treatment. In addition, relevant titles were identified in an electronic search of the Edge Hill University (EHU) library catalogue. A manual search was also carried out in the following peer-reviewed journals: The Arts in Psychotherapy; The American Journal of Dance Therapy; and Body, Movement and Dance in Psychotherapy. Finally, the reference lists of the papers and books that were identified as relevant for this literature review were searched manually.

2.1.2 Inclusion and exclusion criteria

The hierarchy of evidence suggests a framework to evaluate research and its findings and in relation to clinical research, in order to determine effectiveness and appropriateness of interventions (Evens 2003). As a result, the definition of what may be considered as evidence is clearly defined in relation to the types of study utilised. For example, according to this framework results from quantitative research are considered to be higher on the hierarchy than findings from qualitative studies. However, other frameworks for evaluating evidence have been suggested as more appropriate for the creative arts therapies, for example in dramatherapy, whereby a wide scope of practice-based studies may be considered as evidence and appropriately reflective of available and relevant work (Dokter and Winn 2011). Different frameworks which accounts for qualitative as well as quantitative research were proposed for evaluation evidence from art, drama and music therapies, and in which a wide range of expert-based papers are shown as grounded in clinical practice, and therefore evidencing perceived value of clinical work (Gilroy 2006; Dokter & Winn 2011). To date, no alternative suggestions to the hierarchy of evidence have been made in relation to DMP.

Considering the above, for the inclusion criteria for this review I chose to include different types of studies and clinical accounts from a variety of publications, such as peer reviewed journal articles and book chapters, and as suggested by Dokter and Winn (2011). Furthermore, as this thesis follows a qualitative phenomenological methodology and is concerned with understanding processes rather than evaluating outcome, I feel that all papers that can shed light on the research topic ought to be included. Therefore, the inclusion criteria remained broad with regards to type of study and publication in order to include all articles, book chapters, research projects and clinical and theoretical accounts that may further the original contribution to knowledge this thesis has aimed for.

Inclusion of published literature sources was based on the following criteria:

1. The sources had to be written in English, mainly because of the lack of resources and time to engage in translations.

2. The primary modality used was either DMP or BP, or both.

3. Papers were included when treatment of psychological trauma was discussed as the main pathology.

Papers were excluded if they were as follows:

1. Not in English.

2. Did not focus primarily of DMP and/or BP but were concerned with other embodied and somatic practices: for example, physiotherapy, yoga or therapeutic dance practices such as five rhythms.

3. Did not target treatment of psychological trauma as the main pathology discussed but, for example, focused on treatment of brain trauma caused by stroke, or physical injuries.

2.2 Part one: Psychological trauma

2.2.1 Definitions and descriptions

DSM – V (2013) outlines different categories of possible posttraumatic disorders over approximately 30 pages, without clearly defining what traumatic events are. Instead the reader is referred to a long list of potential occurrences which may (or may not) be associated with trauma. Van der Kolk (2003) named interpersonal violence on familial, social and political scales as circumstances which pose a sufficient degree of personal threat as so to overwhelm the survivors' capacity to cope with the experience, resulting in trauma. Indeed, some events such as sexual violence and war atrocities are widely viewed as almost certain to exert a traumatic effect on survivors (Baum, 2009; Harris, 2009; Herman, 2012; van der Kolk 2015). However, the exact form of pathological manifestations and posttraumatic symptoms which may result from exposure to given adversities greatly varies, and with frequent comorbidity as a complicating

factor (van der Kolk, 2015; McFarlane, 2017) it is difficult to predict how trauma may manifest in individual cases regardless of causal similarities.

Caruth (1995) argues that there are many possible causes of trauma that objectively may not appear as harmful and yet be experienced as overwhelming and impossible to make sense of for the survivors. According to Herman (1994) in a similar vein, what signifies a traumatic event is the survivor's experience of helplessness and fear of annihilation that overwhelm their sense of meaning-making. Therefore, I suggest here that it is not the event itself but the perception of the experience by the survivor that determines the likelihood of trauma effect. What is currently agreed upon, however, is that trauma can happen in various conditions, and the range and depth of human response to it makes it one of the most complex mental health issues in the world today (Van der Kolk, 2015). The lack of an established definition of traumatic events may serve to affirm the complexities and diversities of personal experiences and human responses to adversities. To acknowledge this complexity, I thus advocate the notion that the experience of trauma is being rooted in its perception as such by the survivors; therefore, it may be useful to consider the individuality of clients in relation to diagnosis.

2.2.2 Traumatic memories

Schachtel (1947) defined memory as the capacity for reconstructing past experiences and incorporating them into the person's existing system of meaning and understandings. This integration mechanism appears to be much influenced by the emotional state at the time of the experience, which is therefore likely to determine subjective perception. Porter et al. (2001) asserted that due to the extremely heightened emotional state associated with traumatic experiences, the ability to process the traumatic memory is significantly reduced. Literature from neuroscience suggests that trauma results in memory impairment, which is seen to be a major factor responsible for posttraumatic affect (Siegal, 2003). Classic work from Janet (1924) described traumatic memories as being split off from everyday consciousness, stored separately and returning to haunt the survivor as re-enactments of the original experience, rather than memories. I suggest that this unusual effect of trauma upon survivors is a key to clinical practice with this client group and one which needs further consideration. One main issue concerning traumatic memories is that they remain seemingly unprocessed and unmodified over time (van

der Kolk & van der Hart, 1995). This mechanism poses a real challenge for treatment: if traumatic memories become disconnected and fixed, the question arises how to access and re-integrate them into a cohesive and processed experience.

The fractured quality of traumatic memories suggested in the neuroscience literature links with Caruth's (1995) and Laub's (2013) ideas that trauma is an event that cannot be known at the time of its occurrence. Traumatic memories are seen to exist as a contradiction, distinguished by the way in which they are vividly remembered and in the way in which they are forgotten, or rejected by the survivor (Caruth, 1995). This paradox of recollection is often reflected in survivors' accounts. Testimonies of atrocities were often deemed unreliable when related in a confused and emotional manner; in many cases the perpetrator's version, transmitting an orderly narration of events, is accepted while the survivor's account is dismissed due to possible incoherence and confusion (Herman, 1994). This highlights an issue survivors can have with verbally articulating their experience, which can also suggest difficulties with cognitive processing of the trauma. It is highlighted in this thesis that the methods of treatment should correspond with the nature of the issue, or in other words, where survivors struggle to speak and think of the trauma, it may be most suitable to utilise non-verbal methods, and embodied and creative methods.

Crespo and Fernandez-Lansac (2016) reviewed the literature concerned with narratives of traumatic events and found that survivors of trauma tended to use more emotional and sensory-perceptual content than conceptual. These findings affirmed results from a previous review that associated narratives with dominant perceptual elements and trauma effect (O'Kearney & Parrott, 2006). This neurologically based notion that traumatic memories have a strong sensory component and are linguistically weaker has been established as a current leading theory explaining traumatic experiences and their effect. It is now believed that traumatic memories are encoded in the body rather than cognitively and that the trauma is experienced in a perceptual and sensory manner (Ehlers & Clark, 2000; Rothschild, 2000; Fernandez-Lansac & Crespo, 2017). For example, certain sensory stimuli that were experienced during the traumatic event, such as specific physical postures or light coming from a particular angle may not be remembered as having a connection to any experience in particular. And yet, even though these sensory cues may not be consciously associated with the trauma, there can be a link to the

traumatic memory, turning these cues into triggers which can ignite posttraumatic responses when met with in everyday life (van der Kolk, 2015). This being the case, I argue here that trauma-treatment needs to take these factors into account and address the sensory and embodied aspects of the trauma experience. Bearing in mind that body-based conditionings are not always identifiable or consciously accessible, some consideration needs be given as to the ways in which the embodied memories are accessed and can be incorporated in the treatment.

2.2.3 Categorisation of types of trauma

Relevant literature tends to differentiate between the impact trauma has on children as opposed to adults, as well as to distinguish between single incident trauma, multiple traumatic events (including substantial time gaps between events) and chronic exposure to traumatic events (multiple events formed into a pattern in the victim's daily life) (Weathers, Keane & Foa, 2009; Balaban, 2009). In this thesis I mainly refer to childhood trauma and transgenerational trauma, due to my own personal and familial relationship to these types of trauma and the relevance this has as a factor to the present research. Apart from categorisation based on age and number/length of episodes, possible causes for trauma are rarely compared to one another or grouped together, as that may complicate categorisation of symptoms by way of cause and effect. Similarly, as suggested above, the DSM-V (2013) remains descriptive in its approach to trauma categorisation. It lists a large number of adverse circumstances which are agreed upon as likely to result in trauma without stating commonalities or differences in cause and/or effect. Torture, sexual abuse, war, physical assaults, accidents, illness, bereavement and natural disasters are some examples of the causes for trauma suggested in the trauma literature (Herman 1994; Weathers, Keane & Foa 2009; van der Kolk 2015). This diversity highlights a challenge to trauma research: namely, the difficulty to categorise and clearly differentiate causes for trauma. As a consequence, it is difficult to ascertain which forms of treatment are used for the different types of trauma. Therefore, for the sake of this thesis I refrain from attempting to define what makes an event traumatic, or to categorise treatments and interventions as suitable or otherwise for specific types of trauma.

2.2.4 Childhood trauma

It has become acknowledged increasingly often in recent years that prolonged exposure to adversities in childhood has can have a substantial and negative impact on the survivors' developmental processes (Ogden, Minton & Pain 2006; Foa et al, 2009). Interpersonal trauma occurring in childhood is often a long-term event which may be referred to as complex trauma, developmental trauma and/or attachment trauma, and it is believed to result in profound effects on the survivor, causing a wide range of pathological and developmental damage (Kisiel *et al.*, 2017). The experience of childhood trauma can often remain unknown and untreated, and while the term signifies trauma that happened during a person's childhood, it does not necessarily follow that the client is a child during the treatment.

Schore (2003) distinguishes between the experiences of abuse and neglect in children, noting that, according to research, the former is likely to induce high-intensity aggression, while the latter often results in a low-level or flat effect. Attachment trauma is also seen to be a consequence of childhood experience of neglect, as well as abuse (Ben-David & Jonson, 2017). According to this perspective, these re-occurrences can happen within a certain period of life, as in an abusive relationship, or be chronically repeated over time, sometimes spaced over few or many years (van der Kolk & McFarlane, 2007). Balaban (2009) argues that posttraumatic stress in children can hinder cognitive functioning and negatively affect the child's sense of identity, self-esteem and impulse control. While these findings share similarity to the impact that single-incident trauma may have on adults, what distinguishes the effect caused by childhood trauma is that children appear to incorporate traumatic world-views more fully into their self-perception and sense of identity than adults (Schore, 2003; Balaban, 2009). In other words, when children experience trauma they often adapt to living with the altered reality and integrate traumatic-oriented patterns of thinking and behaving into their psychological structure. Where adults will have experienced a breakdown, or at least be to some degree conscious of the posttraumatic psychological alteration, children tend to adapt to life influenced by the trauma as a coping mechanism.

It has been suggested that childhood trauma often involves a chronic repetition of traumatic experiences which can be either seemingly sporadic or patterned within the environment of the

child (van der Kolk, 2015; Ben-David & Jonson, 2017). Herman (1995) used the term 'complex trauma' (p.119) to describe a cluster of symptoms and syndromes seen in survivors of prolonged and repeated trauma. These notions indicate that the presence of childhood trauma and subsequent and related posttraumatic impressions may be very influential in shaping survivors' psychology and physiology. This also highlights the increased possibility of the creation and repetition of negative emotional, behavioural, cognitive and embodied patterns. Following this, I suggest that when prolonged trauma occurs in childhood, and the survivors incorporates its impact on them in their belief system, they may accept abuse and neglect as normal and an inevitable part of reality. This can lead to decreased chances of acknowledging the situation as traumatic as well as an increased likelihood of embedding and repeating the negative patterns throughout life, and subsequently passing these on as hereditary, trans-generationally.

2.2.5 Trans-generational trauma

The notion of trauma as transferred from survivors to their children is an increasingly growing area of study in which interest was evoked when the impact of collective trauma such as the Holocaust became apparent in the offspring of survivors (Baum, 2013; Leen-Feldner *et al*, 2013). Children of survivors were suggested to have embodied some of their parents' symptoms and posttraumatic effects despite never have been exposed to prominent physical danger (Baum, 2013). I propose that this notion of trauma being passed down through the generations reveals much scope for further research in understanding the mechanism of trauma. For example, it would be useful to know whether the effects of trauma are indeed learnt or a consequence of neurophysiological processes, or perhaps a combination of both.

Cavalli (2012) posited that living with a traumatised parent will have direct impact on children. Firstly, survivors of trauma are seen at least as partly absent due to the mechanism of dissociation that is likely to occur, and which will have impacted their capacity to fulfil the child's emotional needs (Cavalli, 2012). Secondly, some posttraumatic patterns were found to be embedded in the parent's daily behaviour, including their world views and perceptions, which the children are likely to learn and incorporate into their own systems of meaning-making (Leen-Feldner *et al,* 2013). It has also been suggested that as children are highly sensitive to their parent, identification is likely to takes place unconsciously and resulting in the child acting

out some (or many) of the issues of the traumatised parent (Kogan, 2016). A systematic review of the topic (Leen-Feldner *et al,* 2013) concluded that there was some correlation between posttraumatic symptoms presented by parents and consequent trauma-related impact displayed by their children; however, the overall relationship between cause and effect was seen as inconsistent. In other words, there are many variables to be considered when looking as the impact that a traumatic history of parents may have upon their children, and the ways by which trauma is transmitted across the generations. While the relationship between cause and effect may need further investigation, research indicates that children to traumatised parents are at risk of experiencing posttraumatic effects. This notion is of particular relevance to this research as it is linked with my personal background of growing up with traumatised parents and embodying posttraumatic patterns of thinking and feeling in the process.

Overall, current research highlights additional aspects of the impact of trauma with regards to its trans-generational characteristics and subsequent impact on the offspring of survivors. This notion adds weight to the need for further developments in treatment. Current research indicates that the complexities of the impact of trauma are increasingly being acknowledged as subtle, individually based and with far-reaching implications. Trauma treatment, therefore, needs to account for the wide range of posttraumatic conditions, especially in light of the likelihood that its impact may be hereditary. Indeed, without appropriate available treatment, trauma can have a negative impact in time and space expending far beyond the original traumatic event.

2.2.6 Evidence-based treatment modalities

The criterion by which treatment is often evaluated is its success or efficacy concerning the reduction of symptoms' frequency, intensity and/or severity (Foa *et al,* 2009). Research indicates that trauma-informed CBT, including exposure and cognitive restructuring methods, and EMDR, are currently seen as the most effective evidence-based methods for trauma treatment (Bradley *et al,* 2005). However, Foa et al. (2009) suggest that there is a research bias influencing the existing evidence-based knowledge, in that some treatment approaches are more amenable for randomised and controlled research than others. Therefore, following this line of argument, those treatment methods will have enjoyed greater research popularity and as a consequence they would have generated more knowledge (Foa *et al*., 2009). From this it can be

argued that existing evidence is perhaps limited as it may not reflect the full range of available treatment methods for trauma. For example, research papers that support the value of DMP for the treatment of trauma are limited, which then potentially reduces the chances of further research-funding, as the result of professional anonymity. It is possible that DMP may have been found to be equally effective for treatment of trauma, had there been sufficient resources made available for measuring its efficacy with this client group.

The CBT approaches for trauma treatment are founded on several social-cognitive theories that focus on the impact trauma has on the individual's belief system (Cahill *et al*, 2009). For example, a notion founded on contemporary learning theories views posttraumatic symptoms, such as re-experiencing and arousal, as resulting from emotional responses that were conditioned during the trauma event(s) (Palm & Follette, 2011). According to this idea, survivors of trauma may misinterpret everyday situations and respond as if the trauma was re-occurring, resulting with inappropriate and exaggerated reactions to present-day situations. The methods used by CBT highlight these behavioural tendencies and employ mental exercises in an attempt to change posttraumatic responses. However, if it is indeed agreed upon that trauma has an embodied component, I would suggest that the use of cognitive and behavioural interventions may be insufficient for the recovery process as these do not address all aspects of the trauma experience. Furthermore, I propose that the body of the person needs to be involved in the therapeutic process in order to access the embodied memories of the trauma and thereby support access to the cognitive, emotional and social parts that were impacted as a result of the traumatic experience.

The other evidence-based treatment method discussed here is EMDR, which utilises rapid eye movements to desensitise and process traumatic memories. This method was developed specifically for the treatment of traumatic stress and though relatively new (it was first introduced in the late 1980s), empirical evidence suggests it is an effective treatment method (Spates *et al*, 2009). According to Shapiro (2001), pathological structures are founded on static and insufficiently processed information from early impressions of trauma experiences, which are stored in the survivors' nervous system. Present-day stimuli trigger posttraumatic responses and beliefs which then result in the survivors acting in a way consistent with the earlier trauma experience (Shapiro, 2001). According to EMDR, unprocessed memories of images, emotions

and sensations form the foundation of dysfunctional responses, which are meant to be rectified through a working protocol that involves, for example, visualisation and rapid eye movements (Shapiro & Maxfield, 2002). While EMDR is indeed evidence-based, its structured work method does not account for the diversity of individual experiences and the effects of trauma nor does it allow for different ways of processing it. As in a similar argument made earlier concerning CBT, I suggest that not enough emphasis is placed in this modality on the client as a whole person: physical, emotional, social as well as cognitive.

A number of meta-analyses have been conducted to evaluate the relative effectiveness of different psychological treatments for survivors of trauma without reaching conclusive findings to evidence one method as more effective than another (Bradley *et al*, 2005; Bisson & Andrew, 2007; Benish, Imel & Wampold, 2008). A meta-analysis carried out by Gerger et al. (2014), for example, indicates that different psychological treatments for PTSD yielded similar benefits. However, Gerger et al. (2014) also found that supportive therapies (non-specified in this paper) may be equally effective for treating PTSD as CBT-based treatment approaches. A study investigating asylum seekers' experiences of Trauma-Focused CBT (TFCBT) indicated that the participants' experiences of the treatment were mixed and ambivalent (Vincent *et al*, 2013). This research group found improvements in concentration, appetite and self-esteem but a lack of change in relation to frequency/intensity of nightmares, sense of shame and levels of anger. The research reported that participants found the TFCBT difficult and anxiety-provoking; however, findings also indicated that elements such as the therapeutic relationship and trust in the therapists' skills were perceived as the most helpful factors for the participants (Vincent *et al*., 2013). Therefore, I argue that there is no conclusive evidence that approaches such as CBT and EMDR, for example, are more effective or indeed more helpful than other modalities despite the latter being less established. I also propose there is much scope for further investigation of different modalities as useful treatments for trauma.

What the above examples show is that while CBT and EMDR are regarded as effective evidence-based treatments for trauma, a closer examination of relevant literature highlights some limitations of these treatment options. In addition, the case is made for considering other treatment methods that may have the potential to produce similar effects if appropriate research was to be carried out. I argue here that the factors that support recovery and reduction of

symptoms may still be relatively unknown, as suggested by the above study by Vincent et al. (2013), where trust and the therapeutic relationship were deemed valuable factors that supported the therapeutic process as much as the evidence-based methods. It may be the case that the therapeutic factors that enable progress are similar across modalities and treatment methods for trauma; however, to date there has been only limited research carried out to examine this notion. The embodiment of trauma has not yet been fully investigated in relation to the non-verbal components of treatment, for example. Although there is a growing body of research that compares different treatment options to CBT (Richards and Bower 2011; Pybis *et al*, 2017; Steiner *et al*, 2017), this remains insufficiently investigated in relation to trauma, especially with regards to other forms of treatment.

2.2.7 Creative arts therapies for treatment of trauma

According to Johnson et al. (2009), the creative arts therapies (including Art, Drama, Music and DMP) for the treatment of trauma tend to use the same therapeutic elements as the cognitive-behavioural therapies: namely, imaginal exposure, cognitive restructuring and resilience enhancement. The contribution of the creative arts therapies to trauma work was suggested to lie in the use of the non-verbal and symbolic techniques, which are accessible through artistic modalities to clinical practice (Johnson, Lahad & Gray, 2007). These modalities are seen to offer a protective filter through creating an aesthetic distance that allows clients to work therapeutically while minimising the risk of being overwhelmed by direct contact with the traumatic memory (Johnson, 2009). In the creative arts therapies, exposure to trauma memories is often indirect and filtered through symbolic and creative processing, as opposite to the methods such as EMDR or CBT where a full and detailed recollection of the trauma experience serves the purpose of desensitisation and cognitive re-conditioning (Cahill *et al*., 2009; Spates *et al*., 2009). Indeed, a growing body of literature supported by clinical expertise and anchored in clinical practice documents the benefits of the creative arts therapies for survivors of trauma (Bernstein, 1979; Meekums, 1999; Gray, 2001; MacIntosh, 2003; MacDonald, 2006; Talwar, 2007; Harris, 2009; Sutton & Becker, 2009; Greenwood, 2011; Bensimon, Amir, & Wolf, 2012; Carr *et al*, 2012; Naff, 2014; Peleg, Lev-Wiesel & Yaniv. 2014; Dieterich-Hartwell, 2017). However, and similar to DMP, further research is needed to establish the value the creative arts

therapies may have to offer to survivors of trauma, both as separate modalities as well as a collective body of work.

Talwar (2007) suggests an art therapy trauma protocol for the processing of traumatic memories, drawing upon neurobiological understandings of effect associated with trauma and influenced by EMDR and CBT treatment methods. By utilising paint and papers as the primary therapeutic tools, the clients first discuss a trauma memory and then engage in artistic exploration. This is followed by a verbal exploration of the experience and clients' identification of negative and positive cognitions in their work and in their bodies. The process is then being repeated using new sheets of paper and switching between the client's dominant and non-dominant hands until the clients are assumed desensitised to the trauma memory (Talwar, 2007). The author reported positive feedback from clients and suggested that further research is needed to establish the efficacy of this protocol (Talwar, 2007). In relation to the topic of this thesis, however, as the main artistic method was visual art making this protocol did not include embodied elements that could be transferred to DMP. Perhaps some consideration can be given to the emphasis on the clients' creativity and the combination of verbal and non-verbal exploration. However, these components have already been discussed in the DMP literature.

From the music therapy literature, MacIntosh (2003) reports on his adaptation of music therapy techniques for the group treatment of survivors of sexual abuse, and commented on the need to establish trauma-focused music therapy guidelines. Accordingly, I highlight the similarity with DMP and the gap in the literature and theory both these modalities seem to share. In this approach, collaborative song-writing was used as an intervention to strengthen the participants' belief in themselves and in the group, and was seen as creating new narratives of meaning, linking with recovery and resolution of the trauma experience (MacIntosh, 2003). Drumming as an intervention was used for this client group and was found as having the potential to increase group cohesion, facilitating the expression of trauma-related experiences as well as means to increase self-awareness (MacIntosh, 2003; Bensimon *et al*., 2008). When considering this literature in relation to DMP, it may be important to note that in music therapy the primary therapeutic tools through which the therapeutic process takes place are the musical instruments. This is different from DMP where the medium of self-expression is the moving body. As a result, translating useful practices and relevant theories may not always be possible between

these two modalities in the context of treatment of trauma. However, the gap in the literature which renders further development of trauma-informed music therapy is indeed a commonality with DMP and one which highlights the current state of the art not just in the latter, but also in the former.

Modalities that use drama as a clinical approach to psychotherapy, on the other hand, also utilise embodiment as part of the therapeutic process with this client population and therefore this allows some possibilities of transferring knowledge to DMP. A psychodrama framework known as the therapeutic spiral method was developed by Hudgins (2002) and has been used primarily with refugees and survivors of natural disasters, as well as in private practice. This method highlights the concept of containment as a means to establish a sense of safety and includes the use of role play as a therapeutic tool to support the client in their processing of trauma (Hudgins, 2002). This has some similarities to a DMP case study reported by MacDonald (2006), who discussed how creative and metaphoric movement exploration enabled her client to engage with a re-enactment of the trauma and recovery journey. However, according to this review, DMP does not tend to make use of role play in relation to trauma-informed practice. Mulkey (2004) used a dramatherapy method for group processes which has been adapted by him for the treatment of male survivors of sexual abuse as well as principles for Herman's (1994) 'stages of recovery' trauma treatment. Role play, dramatic re-enactments and externalisations of scenes from the participants' lives: much emphasis was placed upon establishing a sense of safety for the participants to enable them to engage with the therapy (Mulkey, 2004). However, a major difference between dramatherapy and DMP appears to be the emphasis on verbal expression in the former as opposed to the non-verbal expression in the latter. Therefore, while there are relevant drama-oriented theories, frameworks and techniques for the treatment of trauma, the specifications and conceptualisation of DMP can limit the scope of incorporating dramatherapy knowledge.

2.3 Part two: Trauma-informed DMP and BP literature

As mentioned earlier, in this thesis BP is incorporated to support investigating the means and methods that may be useful in trauma-informed DMP. Furthermore, incorporating BP knowledge into this thesis affords the possibility of enhancing and integrating insights that may

support clinical advancement across both disciplines. According to Payne et al. (2016), DMP and BP share some essential similarities in conceptual framing as well as in practice, while acknowledging that further research is needed to establish commonalities and differences. The concept of body awareness as a therapeutic tool, for example, was highlighted in BP literature by Reich (1949), who suggested monitoring shifts in sensory-based awareness in relation to external and internal stimuli, as a means to increase body awareness. From a DMP perspective, increasing self-awareness and self-acceptance was achieved through the noticing of sensory, emotional and cognitive responses within the body and its movements (Adler, 2002; Pallaro, 2006). Therefore, this is an example of a therapeutic notion that was discussed with slightly different emphasis and I propose that examining a BP perspective may support expanding current trauma-informed DMP knowledge. However, I would also highlight that there is a substantial difference between these modalities, in particular in relation to trauma, where, for example, BP literature often presents structured interventions and exercises while DMP emphasises the use of creativity and non-verbal communication as a means to meet clients' individual needs. Therefore, an integration of knowledge from DMP and BP is likely to be limited in scope. Nonetheless, I posit that examining means utilised in trauma-informed BP have enriched and enhanced the research presented in this thesis.

2.3.1 Client populations

From the literature reviewed, authors referred to clinical work with diverse client population in terms of age and gender as well as the context of the trauma history. When reporting trauma-related clinical work, DMP literature seems to utilise specific case studies with complex adverse backgrounds, including childhood sexual abuse and war atrocities as well as survivors of natural disasters. In light of that, BP publications refer to a wider range of traumatic histories, which includes histories of abuse, for example, but also car accidents and bereavement as events that resulted in some traumatic impact for the survivors. A difference in focus on a particular population can be found in that DMP sources often present rich and anecdotal cases while BP reports of clinical work at times cluster different cases as well as various backgrounds of the traumas. This, however, may be a result of differences in professional style conventions of presentation.

The majority of DMP professional literature reports sexual abuse related trauma and mostly refers to women (Bernstein, 1995; Hemlich, 1999; Meekums, 1999, 2000; Mills & Duniluk, 2002; Levy, 2005; MacDonald, 2006; Ho, 2015) and child survivors of sexual abuse (Stanton-Jones, 1992; Harvey, 1995; Devereaux, 2008; Piqueras-Remos, 2015), and in the context of private practice. DMP work carried out with survivors of domestic abuse and in the context of charity organisations was reported by some (Chang & Leventhal, 2008; Devereaux, 2008) while Fargnoli (2017) discussed her work with female survivors of human trafficking. A relatively small number of DMP studies refer to male sufferers of posttraumatic symptoms (Harris, 2009, Helmich, 2009; Piqueras-Ramos, 2015) in a mixture of private practice and foreign aid projects as the setting for the clinical work. Trauma as result of exposure to war adversities was reported by Amone-P'olak (2006), who worked with mixed-gender adolescents, and Harris (2007), who investigated the use of DMP with orphaned boys as part of aid projects, while Gray (2001) described her work with a female survivor of torture, which was supported by a charity organisation. In addition, Baum (2009) discussed the need for a theoretical trauma-focused framework to suit survivors of war and Dunphy et al. (2014) offered DMP as an intervention to a mixed population in post-conflict Timor-Leste as part of an aid project. Other trauma-related client groups that were investigated in relation to DMP trauma-informed practice were bereaved parents (Callahan, 2011) in private practice, and culturally specific traumas that were discussed by Ko (2017), organised through charity associations in relation to a Korean female client, and de Valenzuela (2014), who looked at DMP for Hispanic immigrant women as part of a community project. Finally, transgenerational trauma was discussed theoretically by Baum (2013) and Stanek (2014).

In BP, less is reported about the specifics of client populations. Levine (2010) names a few trauma casualties he worked with as part of his private practice, from sexual abuse to physical assault, with also a large number of survivors of car accidents. Ogden et al. (2006) focuses on attachment trauma in the context of the autonomous regulation system, as seen with children and with adults both in private practice as well as in public health services. Rothschild (2000) did not identify specific trauma-related context but rather exemplified her experience, also in private practice, and suggested a framework through the narrative of a fabricated client. This non-existent individual case study was compiled from anecdotal incidents of multiple clients

Rothschild (2000) treated as a clinician, and this mode of reporting was chosen to maintain anonymity and confidentiality of the individuals with whom she worked. Langmuir, Kirsh and Classen (2012) used BP with women survivors of childhood abuse based in a hospital while Warner et al. (2013) worked with female adolescents with a wide range of traumatic histories and in care homes. Lietch (2007) and Parker et al. (2008) both reported their different aid projects offering short-term BP with survivors of Tsunami disasters, while Lopez (2011) advocated the need to incorporate BP in treatment of trauma, and from a broad perspective without focusing on a particular trauma causality.

Overall, I suggest that DMP literature reports clients with more complex traumatic and cultural backgrounds while BP tends to discuss trauma-informed clinical work from a wider and multi-participant perspective. I also propose that the BP style of reporting may contribute to the establishment of theories and frameworks; however, on occasion it may also appear as generalised when the clinical insights are not grounded in a particular case study. DMP on the other hand often remains close to the anecdotal details of a given clinical case; however, it is rare that theorising of the clinical work is suggested.

2.3.2 Theoretical approaches

It seems that there is an agreement among DMP scholars that the body retains the effects of the trauma and therefore it is through embodied means that resolution of trauma can be achieved (Meekums, 1999, 2000; Harris, 2009; Baum, 2009; Lungmuir, Kirsh & Classen, 2012; Pierce, 2014; Dieterich-Hartwell, 2017; Gray, 2017). The literature reviewed suggests that current DMP understandings of trauma work draws upon two main schools of thought. The first one is of psychotherapeutic origins and often refers to Herman's (1994) model of trauma treatment, while the second one, similarly to BP, is a broader neurophysiological framework used to explain trauma effect. Herman (1994) constructed a four-stage treatment model which includes 1) establishing the therapeutic relationship, 2) creating a sense of safety, 3) working through the traumatic memories, and 4) integrating the process in the present. This model was found as a key reference in a variety of papers and with adaptations to suit DMP's embodied and creative methods of clinical work. The other leading theoretical framework, e.g. the neurophysiological perspective, is often presented in DMP literature in a manner that argues for and justifies the

need for body-based clinical methods to treat the embodiment of the trauma. The degree to which DMP highlights either one of the above perspective varies and may depend on the writer's personal clinical preferences and the theoretical approach ascribed to.

Pierce (2014) advocates an integrated intervention that combines neurophysiological ideas with more traditional psychotherapeutic perception of trauma treatment. This paper focuses on healthy neurological functioning in comparison with the impact of trauma, and, for example, links between a developmental need to feel safe with the neurological capacity to self-regulate. The framework suggested in this paper is DMP-oriented and draws on theoretical notions from BP and EMDR as well as psychodynamic, and provides a theoretical foundation for trauma work (Pierce, 2014). However, the practical application of these theories in clinical DMP practice is not detailed, nor is there a client group specification. Another current theory for understanding trauma and its effects found in DMP literature is Porges's (2011) polyvagal theory, which links neurophysiological notions of survival mechanisms and theories concerning social and behavioural engagement, integrated through the functioning of the autonomous nervous system. Gray (2017) advocates the usefulness of the polyvagal theory to DMP as she suggests it allows for a positive perception of defensive mechanisms such as dissociation, which in turn may enable self-acceptance and support recovery. Gray (2017) presents a case study of her work as a psychological first-aider in the wake of a natural disaster, an earthquake in Haiti, and discussed her clinical experience in this context through the lens of polyvagal concepts. So, in this paper, polyvagal notions are used to add theoretical meaning to the work done, rather than influence it. Therefore, it seems that the polyvagal theory is utilised to explain embodiment of traumatic experiences and justify the use of DMP with this client group. However, limited reference was found to the ways by which this theoretical framing of trauma effect aided the development of interventions or enhanced the working knowledge of trauma-informed DMP.

Dieterich-Hartwell (2017), similarly to Pierce (2014), offers a reference model that combines knowledge from neuroscience and psychodynamic theories and suggests a DMP framework that is founded on the concept of introception as the exit point to an embodied practice. This concept was argued as holistic as it aims at integration of different aspects of the trauma experience, and appropriate for DMP due to the use of body-based emotional information processing (Dieterich-Hartwell, 2017). Also similarly to Pierce (2014), this model is presented theoretically and

without a reference to any specific cause of trauma and/or client population. This paper is another example of a possible meeting point between DMP and BP as many similarities can be found between this idea of introception and Rothschild's (2000) suggestions of utilising the sensory system to increase awareness and autonomy. In addition, this theoretical model may also be drawing on ideas developed by Ogden et al. (2006), which also aim to increase embodied awareness and restore self-regulation capacity. While neuroscience is increasingly used to explain and understand the mechanism of trauma and its effects, little has been found in this review of the literature to inform clinical practice by way of the influence these theories have on DMP's trauma-informed interventions. Therefore, the question remains how to translate theoretical understanding into clinical implications, and in the context of DMP. I highlight this gap between theory and practice that was found in this review and suggest there may be other theoretical framing to conceptualise trauma-informed DMP that can be integrated with the neurophysiological body of knowledge.

From a DMP theoretical perspective, Meekums (2000) suggests the creative process is often utilised for meaning-making and integration of complex and traumatic experiences while non-verbal work is combined with verbal articulation to increase awareness and understanding. Meekums (2000) accounts for the use of the creative movement in group treatment of women survivors of childhood sexual abuse and point to the advantages creative methods can have in facilitating recovery. In her research, Meekums (2000) found that DMP supported the processing of clients' unconscious material and was useful to contain and express past experiences in a non-verbal form, for those clients who struggled with verbal articulation. Van Westrhenen et al. (2017) also suggest the use of non-verbal methods for symbolic exploration, and to enable expression of the trauma experience for clients who struggle with verbal articulation, particularly children. These papers offer an alternative theoretical conceptualisation to that discussed above. I suggest that these papers which discuss the use of the creative process (Meekums, 2000) as well as non-verbal means (Meekums, 2000; van Westrhenen *et al*, 2017) support bridging the gap between theory and practice by theorising the specifics of trauma-informed DMP. In this approach to theory, DMP methods are justified for trauma treatment based on their own merits and without applying notions from other schools of thought but creating a theoretical foundation out of clinical practice.

The leading BP publications identified and reviewed for treating trauma are conceptually embedded in a neuro-scientific understanding of trauma and tend to refer to the effect trauma has on information processing, affect regulation and/or the autonomous nervous system (Ogden & Minton, 2000; Rothschild, 2000; Ogden, Minton & Pain, 2006; Levine, 2010). For example, Levine (2010) discusses the mechanism of fight, flight and freeze and highlights the adrenaline surge that is released in the body at times of danger and as means to increase the person's chances of survival. According to Levine (2010), during traumatic events the person is overwhelmed and freezes, which means the survival mechanism activates the fight or flight mode but with no resolution. Therefore, the adrenalin rises but with no outlet the energy becomes trapped in the muscles, for example, as well as in other parts of the body (Ogden, Minton & Pain, 2006; Levine, 2010). The solution offered by Levine (2010) to the unfulfilled flight or fight is, through a variety of physical exercises, a release of the trauma-oriented tension that was retained and stored in the body and which is believed to support psychological recovery. I suggest that while this notion may be helpful for resolving the physical survival mechanism and release the bodily tension, some further emphasis can be placed on understanding the emotional impact the trauma has had on the client, as well as the physical-neurological.

Similarly, Ogden et al. (2006) also located the roots of the effects of trauma in the lack of resolution of the survival responses, but with greater emphasis on the posttraumatic imbalance in arousal levels which are seen to result in reduced capacity for affect regulation. According to this theory, trauma is understood to produce a negative impact on the autonomous nervous system which is then expressed in the survivor's tendency towards hyper- or hypo-arousal, and exaggerated or inappropriate responses in everyday life and as a result of exposure to triggers (Ogden & Minton, 2000; Ogden, Minton & Pain, 2006). Rothschild (2000, 2010) points to that the idea of humans having dual awareness, and suggested that trauma effect is reflected in various degrees of maladaptation in the survivor's information-processing system: for example, their ability to distinguish memory from present-day situations, also referred to as flashbacks, or re-experiencing. Following this theory, the aim in treatment is to support clients in regaining their dual awareness by which they can overcome some of the trauma effect and have better self-management over their posttraumatic symptoms (Rothschild, 2010).

Overall, it seems that BP's leading trauma-informed methods have a direct relationship with their supportive theories and are in fact potentially constructed in response to them. These frameworks suggest an embodied and often a direct response to what is understood to be embodied trauma effect from a neuro-physiological perspective, i.e. shaking exercises to release stored tension, focus and increased awareness of sensations to ground and bypass flashbacks, and so on. Therefore, I argue that trauma-informed BP in that respect draws from very different frames compares with DMP in so far that it is founded on the notion that survivors of trauma undergo a fixed and shared neurological process that results in known effects, which can be rectified through pre-designed interventions. However, while this approach is effective to some degree, it does not align with the understanding discussed earlier in this chapter that the depth and form of trauma effect is unpredictable as it is impacted by a great number of variables.

2.3.3 Clinical methods

MacDonald (2006) used in her DMP practice methods such as naming and affirming body parts in order to support the client in reclaiming their autonomy over their body, following experiences of childhood trauma. While the similarities between these BP and DMP examples are recognisable, there are some differences in approach to treatment as well as in the mode of report. Similarly, and from a BP perspective, Rothschild (2000) discussed the role of the body in the treatment of trauma and how it is used to anchor and ground the client in the present. Through the use of increased awareness of sensations the clients are encouraged to distinguish between lived traumatic memories and the present-day situation which triggers them (Rothschild, 2000). MacDonald (2006) described making use of the therapeutic space as well as props to allow the client to create a space in which she could ground herself in the present moment and bypass re-experiencing of the trauma. In this clinical example, the client, an adult female survivor of childhood abuse, symbolised her journey out of past traumatic memories and into a hopeful future through creative use of space and artistic means, where she was able to embody and enact her therapeutic process (Macdonald, 2006). On the other hand, Rothschild (2000) offers clear and transferable means through which clients are meant to increase their capacity to manage their symptoms and, by doing so, become more autonomous and potentially

empowered. Therefore, I propose that both the use of DMP methods and creative exploration as well as the BP's use of physical sensations for distinguishing past and present have much potential to enhance a potential trauma-informed framework.

Gray (2001) argues that creative expression is useful for her client's process, an adult female survivor of torture, while attesting to the usefulness of increasing embodied and emotional self-awareness to manage dissociation and fragmentation. By alternating between images and corresponding sensations, Gray (2001) describes how her client's process of overcoming traumatic memories took place in an indirect and often non-verbal manner. In this case study, the client was not asked to recount her traumatic history and instead embodied elements such as a sense of pressure and feeling trapped were used to access and modify the trauma (Gray, 2001). On the other hand, Koch and Weidinger-von der Recke (2009) combined verbal and embodied approaches in their work with female refugees and survivors of sexual abuse, arguing that bringing the two together furthered their clients' integration of their trauma experiences. In the context of this group therapy case study, verbal sharing of trauma experiences resulted with a sense of mutuality to be created, which then enhanced group cohesion and an individual sense of self-value (Koch & Weidinger-von der Recke, 2009). DMP methods such as the Chasian circle, mirroring and vocalisation were utilised throughout the therapeutic process to empower the clients and increase their self-esteem: for example, through rectifying posttraumatic and distorted body image (Koch & Weidinger-von der Recke, 2009). From this it follows that the use of verbal processing of traumatic experiences is optional in trauma-informed DMP, and merits have been identified in both its inclusion and exclusion as an intervention.

According to the above examples, as well as in Meekums' (2000) findings, it is the individual needs of the client that may determine the division between verbal and non-verbal therapeutic means. Nonetheless, and while there is a case to support integration of both verbal and non-verbal means in trauma-informed DMP, it is indeed a great advantage that through creative and embodied methods clients who cannot or will not speak their trauma experience are still able to engage with the therapeutic process. Ho (2015) suggests trauma-specific applications of DMP concepts: namely, space as representing freedom, and place as representing security. While these concepts are supported by clinical mixed methods research, some critique can be made of the research design, the small sample that renders the quantitative findings as inconclusive, and

the fact that the qualitative component was driven by theoretical framing rather than emerging from the data (Ho, 2015). Nonetheless, this study attempted to develop a DMP, trauma-informed framework and as such is one of the very few available papers with this specific aim. Meekums (2000) utilised her research to develop a framework that highlights the creative process in the context of DMP, specifically aiming towards developing a framework for the treatment of trauma.

BP literature tends to link trauma-informed practice and theory, with much emphasis placed on detailed explanations of given interventions in relation to its conceptual rationale. Landale (2009) discussed her work with women survivors of childhood emotional trauma who exhibited psychosomatic symptoms: for example, severe headaches and chronic pain. It is suggested that the clients benefitted from a variety of BP techniques such as breathing exercises and focusing on sensations, as well as body scans, while the trauma effect was discussed in relation to the concept of medically unexplained symptoms (Landale, 2009). Though indirectly, this paper suggest that it may very well be that the symptoms experienced by these women were various embodiments of trauma, a notion supported by a lack of medical diagnosis that could explain the clients' ailments. Clark (2009) used her own somatic and emotional reactions in her work with women survivors of childhood sexual abuse and in doing so, used a more psychodynamic approach to work with the clients' re-enactment of the traumatic dynamics. She gives a theoretical rationale for her clinical choices as well as details of the intervention used, which included shaking exercises to release muscle tension and combination of visualisation and noticing sensations to help the clients ground and re-connect with their bodies (Clark, 2009). Both these studies used a physiologically and clinically direct framework that was often structured and exercise-based. As beneficial as it may be, I argue that this approach may not fully allow the client the scope for a self-directed exploration but encourages following more pre-designed interventions. This is as opposed to notions discussed in trauma-informed DMP literature, where the leadership of the process tends to remain with the clients and be, therefore, a less directive therapeutic approach.

Similarly, Rothschild (2000) provides a detailed account of the framework she used and the guiding principles behind it while bringing case illustrations to demonstrate those principles in action. Her decision to combine and integrate clinical incidents from different clients and report

these as one semi-fictional case study is unusual in professional literature, and is justified as the means of maintaining clinical anonymity and confidentiality (Rothschild, 2000). However, the lack of a direct link to the clinical and personal context of the clients means that the case studies appears generalised and potentially do not reflect the original clinical experience. Generalisation (Creswell & Plano Clark, 2011) can be seen as desirable to establish guideline for clinical practice. However, I argue that this approach has elements of fragmentation in it, wherein clinical material is taken out of its context as embedded in a particular client, and synthesised with other clients' pieces of experience. This attitude towards the reporting and theorising of clinical experience is singular in the literature identified for this thesis and I question the merits of such an approach to carrying out advance clinical practice. A different approach can be found in Levine's (2010) work, which includes clinical accounts of narrated dialogues between the clients and the therapist, as well as details of interventions, thereby linking lived clinical experiences with theoretical insights that he offers. The case illustrations present clinical diversity, including work undertaken with men, women and children who have survived various traumas, such as abuse as well as natural disasters and car accidents. Levine (2010), in effect, offers a non-medical approach to trauma-work by differentiating between the perception of trauma as a disease and the perception of trauma as a human experience that originates in survival instincts. This work includes different techniques: for example, a self-touch exercise where the client applies pressure with their hands on different parts of their body to support grounding during re-experiencing or flashbacks, also referred to as the self-holding exercise (Levine, 2010). The emphasis in Levine's work (2010) is, I posit, on resolving the conflict created in the survivor's body when the fight, flight or freeze mode was unfulfilled when the person was unable to prevent the event from happening. The exercises offered through this BP approach are aimed at re-enacting that survival mechanism in healthy and modified ways. This is an example of a framework where there is a clear interlink between the theoretical framing and the aims and objectives of the clinical practice, where both facilitate and support each other. I suggest that this approach to constructing a theoretical and clinical framework is indeed useful and can be potentially useful for DMP practice.

From a BP perspective, Heller and Heller (2001) used a case report of a female survivor of a car accident to demonstrate Levine's framework, which they suggest was highly effective in that

particular case. They focused on stabilising the client, e.g. establishing a sense of safety through leading questions and increased awareness to sensations, seen as an initial and fundamental stage that precedes trauma processing (Heller & Heller, 2001). The methods used for trauma processing involved visualisation of the event and changing the result which was believed to have caused by the trauma, allowing the client to use her body to act out the actions that manifested the change - for example, kicking and punching - which were meant to, over time, bring about resolution of the trauma (Heller & Heller, 2001). This is an example of a BP, practice-based exploration of a trauma-informed framework, attested to be useful for this client group. On a similar note, Langmuir et al. (2012) conducted a pilot study adapting a sensorimotor approach (Ogden, Minton & Pain, 2006) for the group treatment of adult female survivors of abuse (ranging from physical, emotional and sexual forms of abuse) combining exercises intended to increase body awareness. The sessions were kept fairly structured to maintain the participants' awareness of their bodies rather than use their cognition, and most sessions involved relational work either in dyads or as a group (Langmuir, Kirsh & Classen, 2012). The overall aims were to gradually enhance the participants' capacity for effect regulation through increased awareness of the body level and in a relational context, as well as being better able to be grounded in the present (Langmuir, Kirsh & Classen, 2012). Again, and similarly to Levine (2010), this work present a clearly constructed framework where the theory and the practice are strongly linked together, both in terms of theoretical rationale as well as in practice. However, I suggest that this framework is slightly generalised and assumes pre-determined knowledge of the issues experienced by clients who are survivors of trauma. The notion of effect-regulation as the main aspect impacted by the trauma which needs addressing can perhaps leave out other areas that require consideration as part of a holistic and trauma-informed therapeutic process.

Overall, I highlight here a difference between DMP and BP in the treatment of trauma as seen through examining the above examples. In the latter, the emphasis seems to be on the impact the trauma has had on the nervous system or in relation to the fight, flight and freeze mechanism. Also, in the literature that was identified for this review, BP papers often describe the use of pre-designed exercises, which are also presented as contributions to knowledge. BP literature seems to highlight structured treatment methods and offers general guidance but with less emphasis on individual clients' needs. Furthermore, the structured and physiological conceptualisation of

trauma-informed BP, as represented in relevant literature, does not seem to account for the wide range of trauma effect manifestations and the complex nature of pathological co-morbidity. DMP literature, on the other hand, tends to present detailed clinical descriptions of interventions and authors tend to be sensitive to the personal and individual contexts of their clients, often choosing an anecdotal mode of reporting. I also suggest that much focus is placed in DMP on the use of creativity, the individuality of clients and their process but only limited emphasis on trauma-specific interventions. Therefore, and with the absence of a specific trauma-informed framework as a reference point, DMP literature can potentially be seen as anecdotal and sporadic, with a lack of theoretical cohesion. I propose that it may be useful for DMP literature to follow some of the examples offered by the BP body of knowledge where a trauma-informed framework is constructed in which theory and practice align consistently. A review of the different ways with which clinical work is discussed in DMP literature reveals that while space is afforded to detailed descriptions of interventions and processes, as well as the form in which clients have embodied given therapeutic concepts, there is little by way of a trauma-specific framework that may apply in different contexts. The concepts of non-verbal engagement and creativity are embedded in DMP literature and are a part of the professional and conceptual vocabulary. However, and while some explanation is given to the application of both concepts in a trauma-informed context, I pose that available reports of clinical practice are currently insufficient to support a cohesive development of trauma-informed DMP practice.

2.3.4 The gap in the literature

Mills and Duniluk (2002) observed that DMP literature provides examples of what DMP looks like in practice but does not present a rational or justification as to why certain interventions are used in specific circumstances. Furthermore, I argue that the claim that DMP literature allows the reader to understand the defining features of embodied and creative treatment of trauma is not precise as interventions are not always detailed. Moreover, existing literature often describes the theoretical aspects of the therapeutic process, with little or no description of particular interventions and their applications. Further highlighting this gap between theory and practice, Baum (2009) discusses the relative absence of a coherent DMP framework for treating trauma and posttraumatic symptoms and recommends that further consideration is given to establish it. The theoretical and practical diversity reflected in the DMP literature can also be regarded as

somewhat fragmented and, as such, weakens the claim DMP has as a useful treatment for survivors of trauma.

DMP, similarly to BP, is considered here to show great potential for treating survivors of trauma due to the embodied approaches utilised in the therapeutic process. This means that the traumatic memories stored in embodied and non-verbal forms can be directly addressed through these types of treatment. However, the literature yielded little research-based evidence to support the usefulness of DMP for this population. I propose that this is a potential hindrance for DMP to be established as a useful approach within the wider field of trauma studied. Furthermore, while the literature tends to report successful outcomes, understanding of how and why these potentially successful outcomes were achieved is limited. There is a need to shed more light on the clinical choices made in DMP treatment for trauma to enable understanding of the value this modality can have for clients. While anecdotal description and references to clinical practice are plentiful, a comprehensive investigation of the 'bigger picture' in the context of DMP for trauma is still missing. Furthermore, I highlight that establishing a DMP trauma-informed framework could potentially support professional cohesion and create a reference point for future trauma work. Most case illustrations and examples given in the literature tend to be anecdotal for DMP and somewhat overly generalised in BP literature and are therefore limited in transferability (Lincoln and Guba, 1985). There are merits in establishing guidelines that will be both credible and transferable (Lincoln and Guba, 1985) to support clinical work with this client population (Forester, 2007). For that to be achieved, we must first clarify theoretical and practical aspects of the therapeutic process, which are seen as helpful for survivors of trauma through embodied and creative methods. I propose that therapeutic factors relating to trauma treatment need to be clarified further, along with the embodied and creative elements that are used in DMP in order to ascertain the unique contribution it has to offer to this client population.

Consideration may also be given to the phenomenon of vicarious traumatisation (Pearlman & Saakvitne, 1995; Bober, Regehr & Zhou, 2006) as a professional hazard, especially potent for less experienced therapists (Forester, 2007). Thus, it can be argued that a DMP framework that will articulate guidelines for trauma-informed practice can also be a useful means in preventing vicarious traumatisation as well as burnout. Furthermore, such a framework could also support

therapists to distinguish between primary and secondary trauma, as secondary trauma will not refer to traumatic events and therefore can be more difficult to identify, in particular with children (Forester, 2007; Baum, 2013).

2.4 Summary

Overall, literature highlights that when events have an overwhelming impact upon survivors it may result in trauma which has consistently been associated with a wide range of long-term symptoms. This review of the literature indicates further that posttraumatic effects can vary in terms of severity and manifestations and it is agreed that trauma represents a highly complex condition due to the large number of possible causalities, consequent symptoms and comorbidity. This complexity may be the reason for the manifold forms of treatments that have been developed to address the impact of trauma and posttraumatic symptoms. Current research further suggests that trauma experiences are stored in an embodied-sensory form due to the 'shut-down' of particular cognitive processes, and this notion is becoming more widely acknowledged and implemented in treatment. CBT and EMDR are highlighted in the literature as effective evidence-based approaches for the treatment of trauma. However, several systematic reviews and meta-analyses conducted in recent years did not yield conclusive evidence that either one of these methods is more effective than the other, or indeed more efficacious than other treatment approaches. Selective distribution of resources was suggested as contributing to the current primary focus on CBT and EMDR as evidence-based approaches for the treatment of trauma. I highlight here that the focus on cognitive and verbal therapeutic approaches may also limit the extent by which the embodiment of the trauma and the difficulties survivors have with verbally narrating their experience are considered.

In DMP, exposure to trauma memories is often indirect and filtered using symbolic and creative movement exploration. From a slightly different perspective, BP approaches hold that the trauma is stored in a physicalised form in the muscles and nervous system from which it is then accessed through body-based exercises. In other words, one of the strengths DMP and BP have to offer to trauma work is the possibility of accessing the trauma non-verbally and non-cognitively through embodied and creative means. In light of the impact trauma may have on the survivors' cognitive capacity to articulate their experiences, the non-verbal alternative

offered by DMP methods is highlighted here as particularly relevant to this client group. While non-verbal means to be highlighted in this thesis as addressing a specific trauma effect which may hinder a more cognitive approach for treatment, the review of DMP literature emphasises the importance of combining both approaches and according to the needs and preferences of the clients. I argue that having a choice and the possibility to engage in different forms of therapeutic exploration holds promise for facilitating recovery from trauma.

Most of the DMP and BP papers identified for this review consisted of case examples and untested clinical frameworks and models. However, this body of work makes strong claims regarding the potential for effective treatment approaches, seen through clinical illustrations, case studies and supportive theoretical rationale. Use of embodiment and creativity are discussed in DMP and BP literature as particularly well-suited for treating a condition that is largely believed to reside in the non-verbal and embodied parts of the survivors' psyche. Furthermore, traumatic memories are seen as very difficult to access or process cognitively, which poses a challenge to other, more widely-used form of treatment. DMP in particular can utilise a broad variety of methods by which the trauma can be accessed according to clients' preferences, including artistic, creative and embodied means, as well as cognitive and verbal approaches. However, in this thesis I argue that these claims needs to be validated through appropriate research in order to explicate those therapeutic factors that can further current practice with this client group.

Considering that currently much is unknown regarding the effectiveness of DMP for trauma I suggest here that this thesis is used for an initial investigation that will examine the therapeutic process for survivors of trauma and from a creative and embodied perspective. In doing so it may serve to identify some specific and unique contributions DMP has to offer to this client population. This investigation can focus on the foundations of DMP for trauma to better understand and conceptualise the therapeutic factors that are used in practice and their value. The overall aim is to gain a better understanding of the current practice used for treating of survivors of trauma, and laying the foundation for establishing a trauma-informed DMP framework.

3 Methodology

3.1 Introduction

This chapter addresses the methodological choices I have made to achieve the aims of this thesis: namely, to investigate trauma-informed DMP and better understand the therapeutic processes and their components as utilised with survivors of trauma. I first present my methodological choice to follow a qualitative and phenomenological approach to research, which I contextualise in relation to relevant literature. I then outline the overall characters of phenomenology, the underlying philosophical assumptions, and ontological and epistemological positions I followed when conducting this study. Hermeneutic phenomenology, the specific methodology I used in this thesis, is then described and discussed including the application of key concepts such as the hermeneutic circle and the researcher's interpretation and reflexivity. This chapter then continues to outline the design of the research and the methods used for data collection and analysis. Ethical considerations are presented along with the measures taken to overcome potential ethical challenges. Finally, trustworthiness criteria are highlighted as well as the means taken to ensure the quality of the research.

3.2 The methodological framework

3.2.1 Contextual background

In the review of the literature I found that DMP, as well as the other creative arts therapies, tend to use qualitative methodologies to investigate trauma-informed practice. The methodologies utilised ranged from phenomenology, through grounded theory and case studies and with a focus on rich data rather than aiming at generalised conclusions. Mills and Duniluk (2002), as well as Helmich (2009), used phenomenology to investigate DMP work with survivors of trauma: women survivors of sexual abuse in the former paper, and a man who experienced emotional trauma in the latter. Phenomenology was also used in BP with Bugg et al. (2012), who worked with a group of adolescents who experienced bereavement: in art therapy (Naff,

2014) to investigate professional perspectives of trauma work; and in drama therapy (Pleg, Lev-Wiesel & Yaniv, 2014) to explore a mixed group of elderly survivors of the Holocaust and young adults. Other qualitative methodologies used in DMP are grounded theory, which was used in the context of community work with survivors of natural disasters (Dunphy, Elton & Jordan, 2014), and case studies with women survivors of abuse (Gray, 2001; MacDonald, 2006; Koch & Weidinger-von der Recke, 2009); both methods were identified as fairly common. Case studies were also used by art therapists, for example, reporting on a long-term individual female client reported by Greenwood (2011) and a short-term group of male veterans (Lobben, 2014) as well as Schweitzer et al. (2014), who followed a structured art-based protocol with an adolescent female refugee. A few studies were found to have used mixed methods, such as in music therapy with mixed groups of adults (Bensimon, Amir & Wolf. 2012; Carr *et al*, 2012) and in DMP (Ho, 2015) with women survivors of abuse. However, they were less common than qualitative papers. Quantitative methodologies were also identified as less common and papers included a pilot BP study with a mixed group of adults (Langmuir, Kirsh & Classen, 2012) and art therapy focused on randomised controlled trials with adolescents (Lyshak-Stelzer *et al*, 2007; Pretorious, & Pfeifer, 2010). Therefore, and according to the above literature, I concluded that qualitative approaches to research were the main methodological means utilised for investigating trauma-informed practice within DMP and the other arts therapies as well as in BP.

Following the above, I note that qualitative methodologies and in particular phenomenology are common in DMP as well as in BP and therefore my choice to follow such an approach to research may be deemed as professionally appropriate. Furthermore, my choice to utilise phenomenology in this thesis stems from my understanding of the therapeutic process as a phenomenon that arises from the experiences of both therapists and clients, accessed through individualised and idiographic perspectives. In other words, I propose that psychotherapy is indeed an in-depth investigation of human and individual experience and as such each therapeutic process will vary slightly and be shaped by the individual clients and therapist. Qualitative methodology is used to explore phenomena and derive their meanings, making use of people's stories to gain access into their experience (Creswell & Plano Clark, 2011). The topic of trauma-informed therapeutic processes is still insufficiently understood and under-researched in DMP literature. The choice of qualitative and phenomenological approach to

research corresponded with my conceptualisation of the therapeutic process as experience-based. Moreover, I deemed phenomenology as appropriate to investigate trauma-informed DMP in its current state of the art, where further and in-depth understanding of this topic may further clinical and theoretical knowledge.

3.2.2 Phenomenology

According to Grix (2004), an understanding is required of the philosophical underpinnings of a chosen methodology to inform and carry out a clear and precise study. Following from this, I suggest that attempting to gain a clear notion of the philosophical foundation of phenomenological research may in turn support the process of meaning-making as it enables a methodological consistency, reflected in the data collection and analysis procedures, as well as in the dissemination of the findings. Phenomenology is known as the school of thought concerning the study of human experiences (Smith, Flowers & Larkin, 2009). Phenomenology as a term may refer to the philosophical movement or it may be used as a methodology in the context of applied research, even though the two can often overlap (Sloan & Bowe, 2014). Berrios (1989) suggests that philosophical phenomenology encompasses and merges both ontological ideas about what the world is like and epistemological notions of how the world can be known. According to Drummond (2007) phenomenology is used for a conscious and intentional meaning-making process aimed at understanding the world - not its existence, but its significance. This can follow with the idea that phenomena are anchored in an individual perception that discerns and distinguishes between the meaningful and immaterial in human existence. Furthermore, phenomenological investigation aims to uncover what is accepted to be unknown (Heidegger, 1978), and therefore cannot be anticipated or hypothesised. As a starting point for a qualitative research study, this notion supports an attitude of not-knowing, which indeed opens up the possibilities for new knowledge to emerge.

3.2.3 Ontological considerations

From a phenomenological perspective, the notion of ‘reality’ is a by-factor of a person’s perception of it and a result, reality may be regarded as the individual understanding of it, as

experienced contextually in a given time and place. Heidegger (1978) argued that phenomenology is the attempt to understand the meanings of being in the world, and that the process of meaning-making, subsequent understanding and being in the world are inseparable. In other words, our perception of reality is tied in with our attempts to understanding it whilst experiencing it. From this it can follow that, ontologically, phenomena only exist if they are being experienced by someone who perceives them as meaningful. For example, and in relation to this thesis, I suggest that the therapeutic process exists as a phenomenon that is co-created by the clients and therapists and as a result of mutual agreement on its significance and as such, attests further investigating. As a phenomenon that is experience-based, in this research it will be investigated through people's lived experiences and perceptions of it, as an exit point to their reality. As it was suggested that phenomena are in effect reflections of experiences, the former can only be perceived from an inside-out perspective, as the only perspective that is realistically accessible (Heidegger, 1978). In addition, I highlight here the likelihood that each person's experience is different and the variations stems from, among other things, individual context, or perception of what reality is. In other words, each person will have a different experience due to their contextualised perception – which in turn, determines their sense of reality. This notion is supported by constructionist philosophy that suggests there is no such thing as an objective truth that can be generally applicable (Hammersley, 2011). Therefore, the ideas of truth and reality are suggested here as subjective concepts, which may not be used for generalising, but instead may be instruments to enable insights and understanding that is grounded in personal context.

3.2.4 Epistemological considerations

Following notions of epistemology suggested by Heidegger (1978) and Gadamer (1977), I highlight knowledge here as tied in with mechanism of sense-making, and as a fundamental tool of understanding human existence. This notion dates back to the phenomenological school of thought that suggested different perspectives as the means by which knowledge is conceptualised and attained. Husserl (1965) suggested that in order to consciously reflect upon phenomena, one has to bracket, or separate, any outside influences including pre-conceptions and biases, and this action alone will enable engagement with the phenomenological attitude. According to Smith et al. (2009), Heidegger suggested that Husserl's assertions were too

theoretical and abstract to be used effectively for phenomenological investigations. Heidegger (1978) argued that the idea of anyone stepping out of their own context, i.e. historically constructed set of beliefs, self-knowledge or preconceptions of what the world is, is a mistaken notion. In this thesis I follow the latter suggestion, which means I did not attempt to bracket my beliefs or world views and separate them from the process of investigation and meaning-making. Rather, consideration was given to identify and understand my preconceptions in relation to the trauma-informed DMP in order to make explicit my interpretation, reflexive engagement with the research process and subsequent findings.

Furthermore, I also follow the notion that one must have some experience of a given phenomenon to really know it and be in a position to make sense of it (Moustakas, 1990). In other words, I pose that my embodied knowledge of the topic of this research, which resulted out of my experience of trauma, consequently supported my ability to derive meaning out of it. Merleau-Ponty (1962) suggested that it is our interaction and engagement with the world that originally causes the appearance of the phenomenon and therefore understanding of the phenomenon must include understanding of our effective involvement with it. Moreover, our perception of the phenomenon may in fact be the only means by which the phenomenon comes into existence and therefore our only means to understand it (Merleau-Ponty, 1962). I follow these understandings with the notion that several factors needs to be accounted for, for the resulting meanings to be understood. Firstly, the context from which the original data was gathered should be at least partially known. Secondly, the context of the investigation needs be made explicit, and thirdly the context of the researcher's interpretation (for example, my DMP training and personal experience of trauma) - as all three factors will inevitably influence the analysis of the data (Guignon, 2012; Sloan & Bowe, 2013).

Heidegger (1978) suggested that our meaning-making capacity is rooted in our historical sense of self, learnt pre-conceptions and world views, and that therefore we relate, reject or are indifferent to phenomenal presentations according to the historical meanings those remind us of. For example, the fact I am a qualified DMP practitioner means that my training, my theoretical understanding and clinical experience all influence the way I perceive and understand the process of this research (and the world in general). The contexts from which I understand and

interpret the world determine my discerning process and evaluation of which themes are relevant to the research aims, and which are not. This does not mean to say that it is a methodological weakness or a research flaw, but rather, these are just the specific lenses through which I see the world and I accept these as such without attempting to change or control them. I emphasise that following this epistemological position meant that I needed to maintain constant awareness of the ways with which I interacted and inevitably influenced the progress of this research. Whilst I make no claims for objective knowledge but regard the findings of this thesis as subjective, I make transparent my interpretation process in line with the phenomenological approach to research utilised here.

The other epistemological notion used in this research concerns the role embodiment can play in meaning making processes and as a form of tacit knowledge. According to DMP literature, accessing the wisdom and knowledge stored in the body has much therapeutic benefits (Adler 2002; Levy, 2005; Baum 2009). Merleau-Ponty (1962) argued that the experience of being in the world exists first and foremost through the existence of the body. According to him, the body acts as the filter or channel through which impressions come into consciousness from the outside world (Merleau-Ponty, 1962). Moustakas (1990) distinguished between cognitive/theoretical knowledge and tacit knowledge, claiming the latter is the only means by which comprehension can be made possible. In this thesis I consider the notion of embodied understanding as providing a unique source of knowledge that cannot be accessed in other ways rather than through a direct dialogue with the body. This does pose a challenge to traditional qualitative research that is heavily reliant of words, but in this thesis I argue that the DMP and creative and embodied methods enabled the telling of stories and sharing of experiences in a non-verbal form. I suggest this concept here is a useful and epistemologically-effective methodological approach to the investigation of trauma-informed DMP.

3.2.5 The hermeneutic paradigm

The hermeneutic paradigm asserts that an investigation is based, or grounded, in the researcher interpretation as means to achieve knowledge. The main hermeneutic and phenomenological concepts that were applied during the process of this investigation included the notion of the

hermeneutic circle as the overall framework use: the notions of intersubjectivity and reflexivity as guiding ontological and relational research attitudes; and the researcher's interpretation as the main epistemological tool that was utilised to gain in-depth understanding of the topic of this thesis. Heidegger (1978) claimed that human existence in itself is hermeneutic as life is constructed by phenomena while people, who innately derive meaning out of their experiences, constantly applying interpretation in order to understand the world around them. In relation to this thesis, using this approach meant that I consciously incorporated my interpretation mechanism in a reflexive manner which then enabled me to own both my meaning-making processes and subsequent findings. Smith et al. (2009) suggested that when observing a phenomenon that has an apparent significance for us, some meanings may be easily detected, while there are also hidden and underlying meanings which we are not aware of. When a phenomenon is investigated and is showing itself, its investigation is done with the purpose of bringing into light those concealed meanings (Smith, Flowers & Larkin, 2009). Therefore, and as an example for this research, the phenomenon of the therapeutic process needed to be interpreted and translated while I engaged in reflexive observation of my interpretation process to ensure that the underlying meanings were indeed uncovered.

3.2.6 The hermeneutic circle

The hermeneutic circle is a concept typically identified with the hermeneutic school of thought and refers to the idea that understanding of the whole involves the study of the parts (Smith, Flowers & Larkin, 2009). A hermeneutic investigation is likely to include a repeated movement between studying the parts and the studying the whole in a cycle of an ever-deepening understanding (Gadamer, 1977; Borrett & Kwan, 2008; Rennie, 2012). The premise is that there is an epistemological relationship between the parts and the whole, or the micro and the macro, and the researcher will fluctuate between the two in a cyclical and spiral-like process (Debesay, Naden & Slettebo, 2008). Furthermore, Debesay et al. (2008) highlighted that the repeated examination of the parts on their own as well as in the overall context of the whole is seen to anchor one's interpretation and safeguard against misunderstandings, through a repeated and contextualised re-evaluation of insights. Thus, one's preconceptions that influence the meaning-

making process are gradually revealed and filtered, while the phenomenon, or the thing itself, can appear.

Borrett and Kawn (2008) used the example of the examination of a text, which is made of individual words that come together to create certain meanings to demonstrate the process of the hermeneutic circle. To reveal meanings underlying in the text one must look for the units that makes the whole, i.e. paragraphs, references, key words and repetitions – all of which will be deemed significant by one's interpretation (Borrett & Kwan, 2008). These units of meaning are studied to understand their own individual meanings, then put back together to examine inter-relationships from which some insights into the whole can be derived. For example, a repetition of a certain word can be interpreted as key but its meaning may only be understood from its positioning in the sentence, or its historical context/reference (Smith, Flowers & Larkin, 2009). This process is repeated while every cycle of engagement further reveals the units' meanings in the overall context. Therefore, meaning in the context of hermeneutics is seen as a gestalt, the whole that is more than the sum of its parts (Borrett & Kwan, 2008).

In hermeneutic phenomenological research tends to be an overlapping of the analysis stages due to the mechanism of meaning-making that is being activated from the first engagement with the data, therefore the researcher is committed to a detailed documentation of the analytical process (Smith, Flowers & Larkin, 2009). This is done also to avoid the risk of the resulting findings being too far removed from the original data (Rennie, 2012). However, critique of qualitative research highlights that the evidence obtained through such means is often anecdotal, context-dependent and not generalised, which is arguably seen as a weakness of this type of research (Teddlie & Tashakkori, 2009). Nonetheless, considering all the variables including the relevant DMP literature and the different methodologies described there, as well as the nature of the investigated phenomenon and my own meaning-making preferences, hermeneutic phenomenology was deemed as a valid and appropriate methodology for this thesis. In addition, I was also able to own my subjective meaning-making processes and incorporate them into this thesis to gain insight into the investigated topic. Potentially, engaging with the data in a hermeneutic and cyclical manner yielded much in-depth knowledge due to the guiding

assumptions that the meanings of the investigated phenomenon were hidden, and interpretation was needed for those meanings to be unearthed.

3.2.7 Interpretation

In this thesis I posit that the use of interpretation is embedded in the process through which people make sense of the world around them and therefore it is constantly and continually applied. Gadamer (1977) suggested that the interpretation both determines and shapes our relatedness to the phenomena we encounter. In other words, the significance of phenomena or indeed the meaning of any of their aspects is entirely dependent on the observer's perspective, which in turn is a result of their interpretation. Heidegger (1978) argued that interpretation is used as part of the attempt to understand the meanings of being in the world, and that the process of meaning-making, subsequent understanding and being in the world are all inseparable. Another way to look at this notion is that experiencing and the interpretation of the meaning of the experience are happing almost simultaneously and feed into each other, the result of which is understanding and categorising of the experience – another example of the hermeneutic circle. This notion highlights interpretation as a concept that merges ontological and epistemological ideas, whereby the existence of something is inseparable from the knowing of it.

I suggest here that the therapeutic process exists as an entity created by the clients and therapists. I also suggest such conceptualisation has not been much discussed in the context of trauma-informed DMP which attests further investigation. It was suggested that as phenomena reflect our experiences they can only be perceived from an inside-out perspective, as the one perspective that is realistically accessible (Heidegger, 1978). I also wish to account for the probability that each person's experience is different and the variations stem from, among other things, individual perception and context. This in turn will influence the ways by which they interpret the meaning of their experiences. Therefore, when investigating individual lived experiences, consideration needs to be given to the variations that will inevitably stem from differences in interpretation. This includes the fact that, for example, my interpretation of a given therapeutic concept will be slightly different than that of one the participants. This notion

is supported by a constructionist philosophy that argued there is no such thing as an objective truth that can be generally applicable (Hammersley, 2011). Therefore, the ideas of truth and reality, I suggest here, are indeed subjective concepts which may not be used in an attempt to establish generalised conclusions. Instead, I propose that these concepts can then be instruments to enable insights and understanding by being anchored in subjectively oriented and in-depth investigations. This considered, in this thesis my aim was to allow for the emerging meanings of trauma-informed therapeutic processes in DMP to be revealed and manifest as much as possible. I hold the position that although this seemed subjective, by owning my position with self-integrity, including any preconceptions, I then could get out of my own way and become truly open for new knowledge to be revealed.

3.2.8 Intersubjectivity

Intersubjectivity refers to the dynamic by which that a person is constantly influenced and influencing their environment and this complex relationship with the world is regarded as fundamental to human existence (McLarkin, Watts & Clifton, 2006). The concept of intersubjectivity, as I understand it, ties in with its ontological function and has particular relevance to the hermeneutic paradigm in relation to the researcher's interpretation. I suggest that this constant flux influences all stages of research and that that engagement with the data changes the researcher's perspective, which then influences the way they regard and interoperate the data and so on. From a research perspective, intersubjectivity is accounting for the ways by which the researcher engages and interacts with the participants and subsequent data and is influenced by both in turn. I suggest that this constant flux influences all stages of research and that this engagement with the data changes the researcher's perspective, which then influences the way they regard and interpret the data and so on. I suggest that the intersubjective dynamic is also found in psychotherapeutic treatment where therapist and clients constantly influence each other while the therapeutic process progresses and the relationship develop and changes. Etherington (2007, 2017) discussed this dynamic in therapy and suggested that this exchange between the client and the therapist is inseparable from the therapeutic relationship. This is another meeting point between the methodological principles I have adopted and the topic of investigation and I present it here to highlight conceptual similarities between psychotherapy and hermeneutic phenomenology.

3.2.9 Reflexivity

Reflexivity, according to my understanding, closely aligns with the hermeneutic approach to research in that it accounts for the researcher as the sum of all their experiences as shaping their meaning-making mechanism, or interpretation. Etherington (2007) suggested that transparency in research include accounting for the beliefs and values of the researcher as these are likely to influence the research process. Qualitative approach to research tends to be guided by constructionism as a leading worldview which advocates the inseparableness between knower and knowing as well as suggests that reality is multifaceted and therefore consequent findings will illustrate different perspectives (Teddlie & Tashakkori, 2009; Creswell & Plano Clark, 2011). The notion of context has been extensively discussed both in relation to reflexive (Etherington, 2007, 2017) as well as hermeneutic (Smith 2011) research. The use of context as grounding given research findings in the particular understanding of individual researchers can then further establish these findings not only as subjective truths, but also as valid forms of knowledge. Gergen et al. (2013) argued that the way to understand others goes through understanding the stories that they tell, and which are more than the content that is being explicitly shared. In other words, the background, language, culture and so on are important factors that will determine different meanings and subtleties of nuances that are being communicated through the stories people tell. To understand those, one needs to account for the context from which the stories are told. Furthermore, I would argue that to understand the context of other people, I must first identify the context of my own story, in order to systematically see the overlaps and differences between my own story and that of my participants. This is the exit point in which reflexivity as a research tool was incorporated with the hermeneutic paradigm for the writing of this thesis.

I propose that, similarly to hermeneutic concepts, reflexivity is in line with the idiographic and experiential nature of psychotherapeutic treatment (Etherington, 2017) as well as supporting the methodological choice of hermeneutic phenomenology in order utilise individual perspectives as means to understand the investigated phenomenon. In addition, qualitative methodology is often utilised to gain insights into and in-depth understanding of the meanings of the topic of

investigation (Richards, 2005). In short, I argue here that hermeneutic phenomenology and reflexivity are epistemologically and ontologically related and appropriate to effectively address the research questions. In this thesis, I used reflexivity to highlight my active involvement with the research process, which is presented in the form of my on-going interpretation and meaning-making narrative that is embedded throughout the thesis. Owning my interpretation and clearly present it as contextualised in my personal background was a methodological choice influenced by reflexive notions.

3.3 The research design

3.3.1 Strand 1: Semi-structured interviews

Qualitative research methodology is associated with narratives that describe the subjective lived experiences of the participants, commonly translated into words (Teddlie & Tashakkori, 2009). In this research strand I employed semi-structured interviews as means for collecting therapists' lived experiences of creative and embodied clinical work carried out with survivors of trauma. The interviews concerned the lived experiences of DMP and BP therapists and their perceptions of treating survivors of trauma. The aim was to derive practice-based knowledge that will enhance understanding of the therapeutic process and its components from a trauma-informed perspective. I argued earlier on in this thesis that there is a gap in DMP literature whereby the therapeutic process has not been systematically investigated and as a result may not be fully understood. The need for further research in this area has been previously highlighted (Meekums, 2010; Dieterich-Hartwell, 2017). To that end, and to include any empirical data in this thesis that can ground consequent findings in clinical practice, semi-structured interviews were conducted with registered DMP and BP therapists who are experienced in working with survivors of trauma. The recruitment process involved purposive sampling in the first instance, followed by a snowball sampling method (Cresswell & Plano-Clark, 2011). Nine interviews overall were included and conduced utilising an interview schedule I developed, and with which I attempted to create discussion opportunities that might enable insight into the topic of research (see Appendix E for the interview schedule).

The interviews were conducted bearing in mind notions of intersubjectivity and reflexivity, i.e. the influence I as the researcher have had over the participants and vice versa, whereby the interview was a product of co-creation. I engaged with the interviewees in a reflexive way, knowing that my responses to each participant and their individual lived experiences influenced the data collection process as my interpretation of each response from the participant would influence the next question I posed. I suggest that the result is a meeting point between my attempt to understand and the participant's attempt to communicate their stories of clinical work. These two perspectives hold slightly different meanings despite sharing the same experience (i.e. the interview), yet I hold that both parties have deepened their understanding of the phenomenon in the process (Borrett & Kwan, 2008). I perceived these interpersonal interactions as a mutual attempt to give and receive knowledge which is reflexive by nature and would inevitably result with some degree of increased understanding. I also suggest the possibility that the participants felt more comfortable being interviewed by a researcher who is 'one of them' than they may have felt with someone from outside of the creative/embodied therapies. I present this factor here as a possible contextual variable which may have influenced the data collected. In other words, it may have made the participants feel more likely to be understood and more open in their discussions. On the other hand, it may have also influenced the participants to relate less contextual content as there may have been an assumption of my pre-existing knowledge. While it is not possible to test this notion as part of this thesis, I propose that the participants related to me in a specific way due to my known professional background, which was likely to have been a contextual variable that has influenced the data collection.

3.3.2 The interview participants

To ensure participants' clinical experience was relevant to this research, inclusion criteria named DMP therapists and BP psychotherapists with at least three years of clinical practice treating survivors of trauma. Sampling was initially purposive, done through an electronic recruitment process and based on participants' self-nomination. Then later a snowball sampling procedure was adopted (Creswell & Plano Clark, 2011). The sampling divided as follows: self-nomination: N=6, snowball: N=3. The recruitment and interviewing procedures took place from July 2015 to December 2015. From the nine included participants, the sample was divided as follows:

Dance Movement (N=7), and BP (N=2). Information pack was distributed to the participants prior to the interview and included an information sheet (see Appendix B) and a consent form (See Appendix C) while a debrief form (see Appendix D) was sent following the interview.

3.3.3 The interview procedure

Interviews lasted approximately one hour, and were conducted and recorded electronically. The interview schedule was designed in accordance to the hermeneutic phenomenology stance, taking into account differences in contextual frameworks and languages, thus maintaining a general line of questioning, rather than a discipline-specific one (Smith, Flowers & Larkin, 2009). The participants were asked about their experience of clinical work with survivors of trauma, their perception of the therapeutic elements that contributes to positive change and of their understanding of the therapeutic process (see Appendix E). The questions were phrased using general terms such as 'therapeutic process' and 'experience of practice' in a deliberate attempt to create a schedule that was open enough and allowed the participants to interpret the questions organically. The same interview schedule was used with all participants, with slight variations having been made according to the interview flow and the participants' choices of focus and to allow for an in-depth discussion of the topic (Smith, Flowers & Larkin, 2009). Participants were given the choice of electronic means used for the interview, i.e. Skype (N=6) or Collaborate (N=3).

3.3.4 The analysis of the interviews

Interpretative phenomenological analysis (IPA) is a qualitative approach that stemmed from the hermeneutic paradigm (Smith, Flowers & Larkin, 2009). I chose this as a method for the analysis of the interviews as it offers a systematic, in-depth and interpretation-based approach which, I felt, supported trustworthiness of the research (Lincoln & Guba, 1985). IPA aims at understanding idiographic perspectives from the third person position through intersubjective analysis (Smith, 2011). Smith et al. (2009) suggested that we cannot access someone else's experiences but we can engage with it through the intersubjectivity of the meaning-making process. This means that in the act of interpretation, we become a part of a new experience that

involves the lived experiences of the participants and our engagement with it. IPA asserts that understanding of the world requires understanding of an individual experience and to do that, I as the researcher need to be able to understand my own experiences as well as my preconceptions and presuppositions (Smith, Flowers & Larkin, 2009). IPA highlights the need for ideographic analysis and a corresponding and structured work method was suggested to enable the interpretation applied by the researcher to be rooted in the experiences of the participants, as reflected in the interview transcriptions (Smith, Flowers & Larkin, 2009) (for analysis examples see Appendices F, G & H).

In this research, IPA was used for analysis of the interviews only, and did not inform the conducting of the interviews. This is because IPA as a methodology explores the individual participants' ways of making sense of their experiences and the world around them, their pre-conceptions and so on (Smith, Flowers & Larkin, 2009; Smith, 2011). However, this research was concerned with the therapeutic process in the context of trauma treatment, rather than understanding the lived experiences of therapists who treat survivors of trauma. As a consequence, while the experiences of the participants as emerged in the interviews were highly valued, the focus was not upon their own ways with which they made sense of their practice but on their perception of the therapeutic process. This focus of the research and its aims were explicitly stated in the information sheet (see Appendix B) and the participants voluntarily and generously engaged with me in a mutual attempt to understand the phenomenon of trauma-informed therapeutic processes, and from DMP and BP perspectives.

The analysis process consisted of a systematic engagement with the data in a few stages, following the work method suggested by Smith at el. (2009). The interviews were first transcribed and initially analysed during the transcription process, through initial thoughts and questions that have arisen from the data and were noted down. Then, to annotate the transcriptions effectively and coherently, a three-column table was used for the first stages of the analysis, with the original transcript positioned in the middle column, leaving the left and right columns free for annotated comments and themes. (See Table 1 and Appendix F).

Table 1: IPA analysis - example

Emergent themes	Transcript	Exploratory comments
Typical individual session structure Therapeutic contract/ Affirmation – clients goal in therapy	A: well, the typical individual session is that I first listen to people and since I have a systemic approach, umm, I ask them about the therapeutic contract, you know, like, what's, what's your goal, eh, for the therapy in general or even for the session of today	Typical individual session Setting long/short term goals? Client's aims for the therapy? Mark the beginning of the process

Then the transcription was re-engaged with, and the annotated interpretations were re-examined in relation to the data and condensed into emergent themes noted on the left-hand-side column. This process was repeated with each interview until all nine transcriptions were fully annotated and completed with emergent themes. The next stage aimed at establishing commonalities across interviews, following patterns that already began to emerge. This stage of analysis involved clustering similar emergent themes together based on similarities of topic or content. The resulting table contained more than 500 emergent themes and stretched over 60 pages. The emergent themes were then clustered together into subordinate themes (for examples, see Appendices G & H). The subordinate themes were then abstracted and clustered further into superordinate themes that comprised the findings from this strand. The final consolidation of analysis was done during the writing up of the findings, when the super-ordinate themes were re-arranged in categories and checked against the interview transcriptions. This was the culmination of the analysis where the interpretation process and findings were reviewed against the original data (Debesay, Naden & Slattebo, 2008). To ensure the findings accurately represented the participants' experiences, interview extracts were used to evidence the link between the data and the findings, via my own interpretation and meaning-making process.

3.3.5 Strand 2: Heuristic Inquiry

The term 'heuristic' was coined by Moustakas (1990) who developed this approach to answer the need for a different type of research that would "incorporate creative self-process and self-discovery" (Moustakas, 1990, p.9). Epistemologically, heuristic inquiry is founded on the notion that understanding can only result out of self-experiencing and through an internally-focused creative investigation process (Moustakas, 1990; Lyddon, 1995). As a research approach it builds upon phenomenology in the sense that the investigation revolves around the experience as the manifestation of a given phenomenon. Furthermore, heuristic approach relies upon the researcher's subjectivity and personal experience as the central epistemological tool, making a conscious use of it to enhance subsequent understanding (Lyddon, 1995). Heuristic inquiry draws upon principles similar to that of the hermeneutic circle as it follows a cyclical method of engagement with the investigated phenomena. In this thesis I used the heuristic inquiry approach for an embodied investigation of the findings gained through the interviews. Drawing on the principles of the hermeneutic circle I wanted to add creative and embodied elements to the interpretation and understanding process and to ensure the circle of investigation ends embedded in practice rather than theory. Also, the use of creative and embodied means aligned with my own preferences and mechanism of meaning-making, which requires an active and kinetic engagement as means for understanding.

The structure of the heuristic inquiry offers six stages that are seen as necessary to gain understanding and, similar to hermeneutic notions, are considered as drawing upon the organic process of human meaning-making (Stromsted, 2001). Those six stage are as follows: 1. initial engagement, when the researcher begins to focus upon the investigated theme; 2. immersion, when the researcher becomes deeply and actively involved with the theme; 3. incubation, when the researcher consciously withdraws from active involvement with the theme, to allow the understanding process to take its course in sub/unconscious levels: 4. illumination, when understanding floods into consciousness and presented as insights; 5. explication, when the illuminated insights take a clear form and can be articulated; and 6. creative synthesis, when understanding has peaked and the different insights merge together into a coherent narrative and representation of the phenomenon (Moustakas, 1990).

In the context of this thesis, heuristic inquiry was used to enable an in-depth investigation of the meaning of the therapeutic process for trauma treatment from a DMP perspective, and through embodied and creative methods. Producing an effective verbal articulation of embodied experiences was regarded as a problem of translation (Gadamer, 1977) because when tacit knowing is verbally expressed, some of its essence is likely to be lost (Moustakas, 1990). I deemed heuristic inquiry as an effective solution as it is meant to enable the researcher to follow a creative strand and is precisely aimed towards an effective communication of tacit knowledge. DMP is grounded in the principles of nonverbal communication and in my understanding, any meaningful DMP research findings need to account for the embodied and creative aspects of its clinical practice. The methods used for data collection and analysis were movement and dance, following the principles of Authentic Movement (AM) as a DMP-oriented movement practice, as well as creative writing. AM enhances body awareness by deeply attending to the subtleties of the movement process and relating it to conscious awareness (including emotions and images) followed by verbalisation of the experience, which serves to expresses the internal experience to the outside world (Adler, 2002; Frieder, 2007; Parker-Lewis, 2007; Stromsted, 2009). Adler (2002) wrote on the roles of mover and witness and referred to AM as a practice aiming at self-development through growing knowledge and trust the mover develops with their inner witness (the conscious, non-judgmental part of herself) as well as with their outer witness (usually the facilitator of the session, a therapist or a peer; Adler, 2002).

Literature suggests that AM can be a useful framework on which to deepen one's relationship with oneself and increase body-mind integration and self-awareness, with particular relevance to practitioners who utilise embodiment and movement improvisation (Musicant, 1994; Adler, 2002; Frieder, 2007; Stromsted, 2007, 2009). In this thesis, the use of AM supported access into the tacit and embodied form of the meanings that the findings held, and enabled bridging between embodiment and verbal expression. Furthermore, this method was used here to bridge theory and practice while it allowed me to take theoretical concepts and examine them through embodied practice, which then resulted with a re-conceptualisation of the findings. In other words, I used AM in this thesis as a method to enable an embodiment of the hermeneutic circle and through which the research aims were achieved and contextualised in DMP practice. Movement was video-recorded as well as noted down in a written and reflective form. Data

analysis (the explication stage of the heuristic inquiry) took place in a cyclical rhythm, where in each session some analysis of previous material was engaged with in movement and subsequent writing. Clusters made out of movement scores and reflective writing were formed into traumatic history narratives that had both verbal and embodied components, and those narratives again clustered together to form a meta-narrative describing a recovery journey – a DMP process for the treatment of trauma. This meta-narrative represented the creative synthesis (the final stage of the inquiry) and took the form of an immersive performance which represented the closing of the overall hermeneutic circle, which was the process of this research. (For the performance see Appendix A; for the heuristic inquiry, see Chapter 8.)

3.4 Ethics

Ethical approval was granted by Edge Hill University, Faculty of Arts and Sciences' Ethics Committee in April 2015. Below are the different measures that were in place to ensure ethical considerations were accounted for in the different strands of the research.

3.4.1 Strand 1: Interviews

For the interviews, the main ethical issue concerned the fact that trauma as a topic of discussion is of distressing nature and much consideration was given to ensure participants' wellbeing was maintained throughout the interview. Information sheets (see Appendix B) were distributed to interested participants outlining the research aims and objectives. Opportunity was given for participants to discuss the interview process and any other relevant details prior to the scheduling of the interview. Informed written consent was required for participation in the project. Consent forms (see Appendix C) were signed and returned to me prior to conducting the interviews. The consent was given in regards to video/audio-recording of the interview, its subsequent transcription and use of the resulting finding in the PhD thesis, and for future publications. Anonymity was kept at all times to such a degree that I am the only person who knows who the participants were as information that could allow for their identification was obscured in the relevant research documents as well as in this thesis.

Participants were made aware that they were able to withdraw their consent up to four weeks following the interview as well as refuse to answer any given questions during the interview and

without enduring any negative consequences (see Appendices B & D). None of the participants followed up on these, however. The participants were asked to state whether they were in regular contact with a personal therapist and/or clinical supervisor who could be contacted if the need arose following the interview and the participant felt distressed by discussing trauma-related topics (see Appendix C). All data were stored anonymously and securely in the facilities of Edge Hill University and electronically encrypted.

3.4.2 Strand 2: Heuristic inquiry

The heuristic inquiry took place either in the facilities of Edge Hill University or at my home. The process of investigation involved self-reflection and self-exploration and indeed was of an exposing and challenging nature. The explored topic was the therapeutic process and its components and no material risk was anticipated. The use of embodied work, though challenging, also serves, for me, the purpose of releasing stored tension. The use of an external witness was providing external support when needed. During the movement exploration and rehearsals, EHU health and safety regulations were observed rigorously and physical safety was ensured at all times.

I have done much work in personal therapy and other methods to de-code my own trauma history and I felt confident in my resources to approach this inquiry without being overwhelmed by it. Furthermore, I felt my wellbeing was secured by the fact that the inquiry was focused upon the therapeutic process rather than the lived experience of trauma. Based on past experiences of undertaking similar projects, I knew that such investigations can indeed be challenging while difficult material is inevitably confronted with. However, engaging with creative processes as research has furthered growth for me in the past and I trusted that this process will take a similar course. I utilised AM as the main method for gathering and synthesising data as well as for providing further containment, which I felt was achieved by the clearly defined framework offered by this movement practice

3.5 Establishing Trustworthiness

The process of developing a qualitative research appraisal framework has seen many evaluation tools developed over the years but used anecdotally (Dawne *et al*, 2009). This issue of evaluating trustworthiness is potentially due to the subjectivist, interpretivist epistemology rooted in qualitative research which rejects the notion of standardised and generalised truths (Walsh & Dawne, 2006). From this I follow that when evaluating qualitative research some amount of subjective interpretation is needed to understand both language and findings, as well as to contextualise both. Therefore, in line with the qualitative methodology of this thesis, the subsequent evaluation will be inevitably subjective. To ensure the quality of this qualitative research thesis, I made use of the key terms established by Lincoln and Guba (1985) in their criteria qualitative research: credibility, transferability, dependability and confirmability.

Credibility refers to the degree to which the findings are reflective of the data and within the context of the research (Lincoln & Guba, 1985; Yardley, 2000; Walsh & Downe, 2006). In other words, and within the hermeneutic phenomenological framing of this thesis, this concept refers to the proximity by which the findings articulate the lived experiences and insights shared by the participants, as captured in the collected data. The methodological choice to use hermeneutic phenomenology allowed me to become aware of my preconceptions and subjective positioning through the process of interpretation. My background as DMP practitioner and my focus on creativity and embodiment were perceived and articulated as biases as well as lenses through which I viewed the data. In light of that, I was then able to use the principles of the hermeneutic circle and examine my findings again in relation to the extracts from the interviews and check my understandings against the data. In addition, presenting the emerging themes to others in different contexts (for example, in conferences, to my advisory team as well as to peers) enabled re-examination of consolidation of the findings and I was able to reflexively acknowledge my own meaning-making towards the establishment of credibility (Lincoln & Guba, 1985; Mills & Duniluk, 2002).

Dependability regards the level to which repetition of the study is possible to help establish consistency of findings (Lincoln & Guba, 1985; Yardley, 2000). Often in qualitative research,

the level of its dependability will be determined by the details describing the research methods as well as by accounting for context-dependent changes (Yardley, 2000; Walsh & Downe, 2006). Therefore, it is highly unlikely for qualitative research to be precisely repeated to the same results, and specifically in relation to DMP and the expression of embodiment and creativity as unique in time and space. However, through maintaining standards of dependability it would be possible to follow a similar process of inquiry that may confirm and enrich previous findings. In this thesis, dependability was maintained, for example, by describing the context of the participants to enable a better understanding of the findings as contextualised, professionally and culturally. Furthermore, accounting for my own personal context as a DMP practitioner who is also a survivor of trauma, as well as my position as a researcher, served to highlight my understandings, preconceptions and biases, which have influenced my meaning-making process and subsequent findings.

Confirmability highlights the researcher's perspective to clarify its influence over the findings, and present a coherent process of interpretation – often achieved through quotations and extracts from the data and openness regarding limitations (Lincoln & Guba 1985; Yardley, 2000; Walsh & Downe, 2006; van Westrhenen & Fritz, 2014). I wish to add to this concept Yardley's (2000) suggestion of the term transparency, by which the researcher is open and clear about their meaning-making process as well as differentiating between the original data and their own interpretation of it. In some respects, this concept includes considerations of reflexivity, by which I argue that it is inevitable that I will have influenced the findings of my research, for example by my DMP background and professed interest in embodiment as means for treating trauma. Therefore, the use of reflexivity throughout the thesis served to establish the confirmability of the research. In addition, the use of IPA with its detailed structured supported the separation between the lived experiences of the participants, as captured in the interviews, and my own interpretation of those. Finally, I attempt to clarify my interpretation and meaning-making process in this thesis, so that my perspective may be distinct and identifiable.

Transferability describes the applicability of the findings to different contexts from that of the original data – which requires a detailed description of the original context of the research and research participants (Lincoln & Guba, 1985; Yardley, 2000; van Westrhenen & Fritz, 2014).

For example, this concept may be reflected in the degree to which the findings may be understood and be of use to clinicians from other disciplines. This notion was highly relevant to this research as a result of including BP-oriented knowledge while the overall research aims concerned DMP practice. Therefore, and in order to establish transferability, I have conceptualised the findings as principles and with emphasis on the embodied component to ensure that applicability is possible for BP practitioners, as well as for clinicians from other disciplines.

3.6 Summary

Overall, I followed the hermeneutic paradigm throughout as a methodological choice, and one which I felt was highly appropriate for the research aims, its topic and context. This methodology enabled me to access and collate the lived experiences of the participants while applying my own meaning-making and interpretation processes as epistemologically justified. In this way I make no claims to meanings suggested from the participants' perspective, but rather own my understanding of the meanings as related to the research aims which is extracted from the participants' accounts of clinical practice. The difference between the two is that I claim no understandings or experiences rather than my own, and it very well may be that the final results would have been, to some degree, interpreted differently by another researcher. However, I argued in this chapter that this will be the case with any type of qualitative research and every researcher has their own unique context, perceptions and preconceptions, which as they are variable will influence their meaning-making process. Indeed, the use of the self as the reference point for any subsequent possible knowledge is intertwined with the notion that the self will always be subjective (Heidegger, 1978). In hermeneutic phenomenological research, the conscious and deliberate use of individual interpretation is used to gain insights into the meanings of phenomena which may as yet be unaccounted for. Therefore the deliberate use of the researcher's interpretation is used to excavate new knowledge, and this was deemed useful in the present instance to investigate the components of the therapeutic processes, which are under-researched to date in a trauma-informed, DMP context.

In addition, I argue that there is a corresponding theoretical conceptualisation between hermeneutic phenomenology and psychotherapeutic thinking in that the individual nature of the experience is acknowledged and valued as well as the intersubjective relationship between variables. The notion that there is constant flux between the researcher and the data (and the participants) is similar to the dynamics of the therapeutic relationship, and the development of both is inseparable from the intersubjective connection between the different factors. Paying attention to the impact I had over the research process, or my reflexivity, is partly where new insights presented themselves, in the gap between my preconceptions and the knowledge I was looking for. Hermeneutic interpretation aims at bridging the gap between our familiar world (what we know) and the new and unknown meanings presented by the appearance of phenomena (Linge, 1977). Therefore, the methodological choice to use hermeneutic phenomenology is also presented here as helpful to researching psychotherapeutic subject areas due to its emphasis on subjectivity, intersubjectivity, reflexivity and interpretation.

4 Findings - The Therapists

4.1 Introduction

This chapter is a presentation and discussion of the findings identified from the semi-structured interviews with the DMP and BP practitioners. These findings supported elucidating the meanings and components of the therapeutic process through an investigation of the lived experience of the participants. Table 2 presents the demographic background of the participants and serves to contextualise the findings within the participants' professional and cultural backgrounds.

An examination of the demographic findings revealed that survivors of trauma as a clinical population indeed formed a very broad domain. The trauma-related clinical issues described by the participants included a wide spectrum of causes of trauma as well as the age and gender of their clients. The clients that were discussed by the study participants were mainly adults but a few of the therapists also worked with children (of all genders) from varying backgrounds. Also, the wide geographic and professional reach of the participants rendered a very broad range of client backgrounds. For example, a BP participant in private practice in the UK worked with survivors of sexual abuse as well as clients who survived car accidents of varying genders and ages; adult as well as child survivors of attachment trauma were treated by a DMP practitioner in a hospital in Finland; and child survivors of various traumas who were treated in a private family clinic by another BP in Canada. However, the majority of participants (five) had experience working with survivors of sexual abuse and of mixed gender, while only a few (three) referred to clinical work done with children. Furthermore, the participants themselves were from varying geographical and cultural backgrounds. Six were from Europe (three from the UK, two from Germany and one from Finland), two were from North America and one from New Zealand.

Table 2 - Demographics

Participant	Professional registration	Length of practice	Work setting	Main trauma client population	Geographic location
1	BP	16 years	Private clinic	Adults/children – mixed survivors of domestic violence, neglect and sexual abuse	North America - Canada
2	BP	20 years	Private practice	Adults – mixed Survivors of sexual abuse Survivors of car accidents	Europe: UK
3	DMP	20 years	Private practice	Adults – mixed Survivors of childhood sexual abuse	New Zealand
4	DMP	4 years	Charity Organisations	Adults/children – mixed Survivors of domestic abuse	Europe : UK
5	DMP	16 years	National Health Services Private practice	Adults/children – mixed Attachment/childhood trauma Survivors of sexual abuse	Europe: Finland

6	DMP	30+ years	Private practice	Adults – mixed Attachment trauma Pre-natal trauma	North America – USA
7	DMP	4 years	Charity organisations	Adults – mixed Substance misuse/addictions Survivors of sexual abuse	Europe: UK
8	DMP	30 years	Private practice	Adults – mixed Survivors of sexual abuse Survivors of domestic violence	Europe: Germany
9	DMP	30 years	Community-based clinic Private practice	Adults – mixed Substance abuse/eating disorders Survivors of sexual abuse	Europe: Germany

I highlight these demographics here as contextual variables that are likely to have contributed to the formation of different perceptions of trauma, their impact and subsequent clinical needs, which in turn will have impacted on the clinical choices made by the participants in their practices.

This chapter brings together four super-ordinate themes, each made of a cluster of subordinate themes describing the participants' lived-experience in relation to their clinical practice with this client group (see Table 10). The findings indicated commonalities of narrative and understandings expressed across the interviews. Many similarities were found in terms of clinical approach as well as the impact on the therapist as a result of engaging with this client group. Some differences were identified as well – for example, the differences in individuals' coping strategies and preferences – and I therefore suggest that diversity was found in the details of clinical practice while guiding fundamentals were commonly agreed on. Therefore, despite the variety of theoretical backgrounds and modalities, when stripped down to the principle level, the insights shared by the participants resembled each other closely. Illustrations of this notion are brought in the form of interview extracts, as well as contesting opinions to highlight the ideographic nature of this research's methodology.

Table 3 - The Therapist: Abstraction of themes

Participants' background

- Personal experience of trauma

The role of the therapist

- Resilience
- Caution
- Acceptance
- Belief in the clients' ability to heal

The humble therapist

- Self-doubt
- Not knowing
- Curiosity

(Note: Super-ordinate themes marked in bold)

4.2 Participants' backgrounds

4.2.1 Personal experience of trauma

In relation to having a personal experience of trauma, a few of the participants shared having had a personal experience of trauma, while one participant voluntarily noted not having been affected by trauma as an important point to be made during the interview. Important to note, that the interview schedule did not include any reference to the participants' own personal histories of trauma.

An example of a participant who accounted for their own personal history of trauma is taken from the interview with P4, a DMP from the UK, and made a link between their own experience and their professional expertise:

> *Everything that I know personally about trauma...The importance of feeling safe, before going into something, into something from the trauma, in therapy. (P4, p.5)*

This participant referred to the concept of safety and referred to their process as a mark that they use in their clinical practice. I proposed that because this participant experienced safety when they engaged with their own process and was aware of the benefits of it, they highlight its importance. This attitude is in line with some of the professional literature; however, examining this extract I concluded that this participant is accounting for their own personal experience as the basis for their knowledge. Therefore, while the concept of safety is discussed in professional literature, this participant has, I believe, drawn much from their own embodied experience when expressing the above idea and perhaps when practising with this client group.

Another example can be found with P1, a BP from Canada, who also spoke of engaging with BP methods as means both for professional development as well as for processing their trauma history:

> *I did it for me personally, I did it for my work but it was also for me personally, because I knew that, in my, in my own body that I had trauma that was not yet resolved, in a bodily way. (P1, p.7)*

In this extract, the participant is referring to BP training they undertook and to the dual benefit that they drew as a consequence. Unlike the previous extract from P4, who implied that their personal journey preceded their professional engagement with this client group, P1 suggested a parallel process. According to the latter extract, it may have been the case that the participant engaged with trauma processing through embodied methods while aiming to improve their skill mix as a practitioner, i.e. through continuous professional development and training. Furthermore, following the analysis I concluded that the decision to engage with body-based psychotherapeutic methods was a personal acknowledgement made by this participant of the embodied aspects of the trauma. Therefore, I suggest that P1 evolved as a practitioner alongside, and perhaps as a result of, their recognition of the embodied therapeutic work they needed for themselves. Looking at the two extracts above I wish to highlight the two different pathways: the first one, where the professional expertise (according to the analysis) resulted out of the personal experience of trauma; and the second one, where the personal and the professional merged and were, perhaps, supportive of each other.

One participant professed not to have had any experience of trauma: P9, a DMP from Germany, who seemed to feel it was important to mention their lack of traumatic history. This participant highlighted they know other therapists who have experienced trauma, and draw comparisons between different histories in relation to the capacity to practice with this client group:

> *Always keep in mind, and, and that is, that it is truly a very difficult thing and unless you are yourself a survivor of trauma, which I am not, but I have colleagues who are, and I know that they have a totally different aura when they work with their clients, because they really understand. (P9, p.27)*

According to this extract, it appeared to me that this participant suggested that being a survivor of trauma is an advantage when practicing with this client group. I understood the reference as related to offering empathy and understanding on the part of the therapist and that this participant cautioned against doing so unless the therapist has undergone the experience and therapeutic process themselves. However, later on in the interview this participant also discussed why not having had trauma can indeed be an advantage for clinical practice, through an account of their personal reflections.

> *And sometimes I had these awful, umm, guilt feelings, you know, when someone was telling me what, eh terrible life situation they had, and then I go home to my nice house and family and whatever, I think oh my god, you know, how – and then to say, no, no, well, it's not going help anybody if I go and live in the slums or something, it's – I have to – I'm going to offer the energy that I have through, this life, to support other people, and so that's, my contribution kind of thing. (P9, p.29)*

Beyond the account of the sense of guilt that was experienced by this participant, an analysis of this extract also revealed that P9 was making a conscious use of their experience of security in relation to their practice with survivors of trauma. I understood this notion to be supportive for this participant in terms of the energy they have available to invest in their work as well as their lived experience of a sense of security, both of which can benefit clients in their process. In other words, I saw that not having had an experience of trauma enabled this participant, firstly, to have specified resources to support themselves and their clients and, secondly, to introduce a sense of security into the therapeutic process through their own embodied experience.

Analysis of these extracts highlighted different notions of the participants having had a personal experience of trauma and how they incorporated these notions with their practice. I concluded that this theme portrayed a tendency of the participants to turn their personal background to an advantage and a resource used by them in their clinical practice, be that their experience of trauma or its absence. I propose that this tendency may be regarded as a mark of positive attitude and professional and personal commitment to growth. Further research is needed to highlight a direct link to DMP in relation to this theme.

4.3 The therapist's role

This group of themes is based on the discussions between the participants that, upon analysis, I perceived as reflecting the responsibilities and attitudes the participating therapists had, or felt they had, towards their clients. I also concluded that speaking in the third person and/or making generalised references signified the participants' assumed guidelines for professional conduct and excellent practice. Therefore, I chose to include the latter extracts in this cluster of themes.

4.3.1 Resilience

I named this theme *resilience* to highlight those accounts that affirmed the capacity of the participants to manage trauma-related clinical material and for the sake of the continued therapeutic process. Having been able to manage difficult details from stories of traumatic histories is highlighted here as important, according to the participants, as it supported the clients as well as the therapeutic relationship.

P2, a BP from the UK who worked in private practice, stressed the importance of being able to withstand clients' stories as well as the ability to remain internally grounded in order to support the clients in their processing of the trauma:

> *And they need to feel that I'm gonna be ok, that I'm not gonna get freaked out by what they're gonna tell me... so then I can handle it, when… particularly with more complex trauma, where people have been, hmm, abused very badly. (P2, p.18)*

This extract signified that this participant felt their strength, or resilience, was a factor which enabled their clients to disclose the details of the trauma story. I speculate that otherwise, and if the therapist was indeed 'freaked out' by the details of the experience, the process may have been hindered by the negative impact upon the clients. I also propose that the resilience, or ability to manage the details as suggested by this participant, is linked with containment and the capacity of the participant to accept the clients along with their, for example, deepest and darkest secrets of having been abused. This idea was similarly discussed by P8, a DMP from Germany who is also in private practice with much experience with survivors of sexual abuse. This participant elaborated both on their own capacity for resilience as well as upon the idea that their clients needed to know the therapist will not be harmed by their stories of trauma.

> *With my decades of experience, umm… I'm not so shocked anymore, so I can hold it, I can hold the story, so that the client knows, that they don't have to take care of me… because that's a big concern, eh, patients have, like, if I tell the story, the other person will be so shocked, umm, that they stop functioning, so I protect other people, eh, you know, by not saying anything… I think that, that's a very important thing, like, I can, handle your story, I can hold it- it won't knock me over... and so, by holding it I take a part of your burden, onto my shoulders. (P8, pp.13-14)*

The first point I deducted out of this extract is that resilience can be a result of experience, and can be gained, or built, over time. The second point, and one which is similar to P2, is that the clients referred to here were also not easily disposed to share details of their history, for fear of harming their therapist. I suggest that this may be a factor that was linked with being overwhelmed by the trauma experience and therefore the clients anticipated that their therapist was likely to respond similarly. Following from that, the capacity of both the above participants to withstand and manage the details of the trauma may have helped the clients to learn to manage their own experience better, in retrospect and as a role model. Furthermore, analysis of both these extracts concluded with my understanding the resilience as discussed above was also playing a part in the therapeutic relationship, as it enabled the clients to trust in the ability of the therapist to manage their process. In other words, I believe that the clients of these participants, according to these extracts, were able to tacitly recognise that the therapists had the capacity to contain them and 'survive' the processing of the trauma without being harmed themselves.

4.3.2 Cautious treatment

Some participants highlighted the need for a certain amount of caution with survivors of trauma, and discussed their clients as having had a high level of vulnerability. P1, a BP based in Canada, referred to the need for caution at the assessment stage and in relation to the details of the trauma.

> *The first session is always kind of an assessment, a lot of history, background information… and I… I… you have to be careful with somebody who has been traumatized, you don't want to ask them to go into too much details because it will be too distressing and too explosive and too overwhelming, and you don't want to access their symptoms right away. (P1, pp.3-4)*

In some respects, this extract is linked with the previous theme in that it refers to the account of the actual trauma and the difficulties some survivors may have to face to retell the story of their experience. I understood this extract as this participant cautioning against going into too much detail so as to not trigger the clients: for example, into re-experiencing. According to this extract, P1 explicitly suggested the possibility of clients being overwhelmed by recounting their trauma and in particular at an early stage; however, this participant did not refer to the embodiment of such an experience and I concluded from this extract that they perhaps tended to utilise more verbal than physical means at the assessment stage. Therefore, the caution they referred to, I deducted, is conceptual and related to the content of the conversations and questioning used for the assessments.

From a different and an embodied perspective, the use of touch during the therapeutic process was specifically cautioned against by some of the participating DMPs. For example, P6, a DMP from the US who had much experience working with women survivors of sexual abuse, was very clear on their position in regards to touch in the context of their practice with this client group:

> *Touch is something that comes up for me, I guess, yeah, I don't think I would go there… unless they were asking for support in that way, and even then, I really wouldn't go there. (P6, p.25)*

According to this participant the use of touch was best avoided apart from in particular cases in which a request for physical support was explicitly made. According to analysis, this participant was likely to have exercised caution even if such a request was made, due to their professed awareness of the sensitive nature of touch in relation to this client group. In light of the specification of the clients of this participant, i.e. women survivors of sexual abuse, I understood the caution and hesitation of incorporating touch in the process as having been highly relevant to the practice of this therapist.

A similar understanding was offered by P5, a DMP from Finland who has been working mainly with survivors of attachment trauma, explaining why touch may have been a trigger for their clients. This participant emphasised that touch was often likely to be a trigger, with particular relevance for survivors of abuse:

> *Touch is something that we need to be very, very careful about... Because it's very strong, touch... I think with trauma clients, it's very sensitive because quite often there's a history of touch which has been very negative, touch has been abusive, and eh… I…I almost never use touch with, with those clients who have been very early, eh…traumatized. (P5, p.18)*

This extract is, I suggest, a clear explanation of the ways in which touch has come to be associated with the trauma experience for the clients of this participant. In light of this perception of touch, and following analysis, I found the need for caution with this client group quite reasonable and logical. However, there may also be the possibility of touch as a positive and corrective factor in the therapeutic process, and I relate here to the reference this participant made to the power of touch. In other words, whereas I concluded the evident need of practicing much caution in relation to touch, I was also left with the question around the healing power of touch and whether it may be, at times, be used constructively and to further the therapeutic process.

A different perspective to the use of touch and the need for caution in relation to it was suggested by P7, a DMP from the UK who worked both with male clients with substance misuse issues who were in rehabilitation as well as female survivors of abuse.

I'm a great believer, actually, in… in moving into doing a bit of contact work, or, of really... Touch, touch… umm… but I really feel that … that's something that again, obviously, you have to be really careful with, and it, it would be… you know, simple, like hand to hand or back to back, or… but I'm very aware in mixed groups how that goes down, or in, in… in the women's group - I think I only ever came to do hands or not even at all in that group, because it felt… it never felt quite right to do. (P7, p.21)

Here, the participant was discussing the use of touch in relation to different clinical contexts. It is interesting to note that, similarly to the two previous participants, P7 also referred to touch as an intervention that they avoided when working with women survivors of abuse, while introducing touch with men who are rehabilitating from substance misuse. According to the analysis, I concluded that touch as an intervention in the context of embodied and creative methods is cautioned against when working with women survivors of abuse.

Following these extracts, I suggest that it was considered safer practice with this client group that they avoided the use of touch. Furthermore, I present this theme here as the only one identified in this thesis that clearly differentiated trauma causality in relation to a given intervention, i.e. caution against touch as specifically made in relation to women survivors of abuse. However, some references made by the above participants also raised some questions for me as to the potential touch may have had as a useful tool in DMP as well as BP, perhaps precisely due to it carrying such meaning for clients. While these participants were clear on the caution required when considering touch with this client group, they did not rule it out and referred to the power touch might have, the possibility of clients requesting touch for support as well as examples of touch as an intervention. Perhaps, given the right circumstances, it may be appropriate to use touch as part of trauma-informed DMP; however, further investigation is required to identify the creative means by which touch can be transformed from a possible trigger to a therapeutic aid. Overall, and according to analysis of the above extracts, the participants were conscious of the need for caution and while touch was used as a central and tangible example, I propose it is a representation of a general approach by which cautious practice is key.

4.3.3 Acceptance

Participants referred to the concept of acceptance and suggested that as a therapeutic concept it may have helped them to establish the therapeutic relationship and enabled their clients to better engage with the process. In that respect, and according to the analysis, acceptance was regarded as a way of making space for the clients and giving them permission to undertake trauma processing on their own terms and at their own pace.

Acceptance was highlighted by some of the participants as a novelty to clients, especially those who did not often experienced it in their daily lives. P3, a DMP from New Zealand who worked with survivors of sexual abuse, positioned acceptance as central to therapy and a factor that differentiated the therapeutic relationship from those found in everyday life:

> *It's not like real life… where I might… not like them anymore or… you know, so that unconditional, you know, that unconditional… attempting for that unconditional, kind of, you know… acceptance. (P3, p.11)*

According to this extract, some clients may have held back on exposing parts of themselves and/or sharing details of their history for fear of losing the affection/regard of the participant. Analysis of this extract showed that this participant utilised an accepting attitude to counter the fears of the clients which may have been learnt through experiences in everyday life, and through offering unconditional regard. I suggest that in line with the professional literature that discussed trauma effect, lack of trust may have been a pressing issue with many of the clients that this participant referred to, as well as issues stemming from neglect and attachment issues. In which cases, I posit, use of acceptance and unconditional regard may have been satisfying deep emotional deficiencies some clients may have developed as result of trauma-related coping mechanisms. However, I wish to highlight that while I felt this notion is conceptually important to clinical work with survivors of trauma, this participant did not suggest what creative or embodied implications the notion of acceptance may have for DMP practice.

P2, a BP from the UK who worked with clients of diverse traumatic histories, referred to this idea in a different way when they explained how they used acceptance to enable the client to normalise themselves:

A lot of people goes like, I think I'm crazy, I must be crazy… and really trying to get people to see themselves as having symptoms that are expectable given what they've been through, and me as, I'm accepting them, and… I'm not seeing them as crazy. (P2, p.17)

What I understood from this extract is that the clients that were traumatised struggle to come to terms with their symptoms. This may be related to the idea expressed in professional literature of trauma effect as a negative alteration in one's sense of self as well as perception of the world. According to this participant, the clients perceived of themselves as crazy as result of the trauma experience and subsequent effects caused by it. Following the analysis, I suggest that what P2 accounted for was introducing acceptance into the process in an indirect form. In other words, instead of suggesting or encouraging self-acceptance to the clients this participant adopted an attitude of acceptance towards the clients including their trauma effects and symptoms. I posit that by doing so the concept of acceptance was introduced into the therapeutic process and was present in an embodied form, through the participant.

These examples are brought here to show how acceptance was used in slightly different ways and with different aims but with similar results of potentially enhanced therapeutic processes. The participants from a BP background intentionally perceived their clients as 'normal' and thereby supported the clients non-verbally and indirectly towards accepting their condition and symptoms. The other strategy suggested from a DMP perspective related more to the creating of an emotional container in therapy, where the participant discussed their offer of unconditional acceptance as inseparable from the therapeutic process. I understood these findings as illustrating the impact the participating therapists have had on the therapeutic process and as a method to intervene indirectly. This notion, i.e. for the therapist to embody a concept and thus introduce it into the therapy without requiring the active engagement of the clients, has not been explored in depth in relation to trauma-informed DMP. These findings also indicate, I suggest, that accepting the clients and their trauma effect can potentially enhance the therapeutic process and the development of the therapeutic relationship.

4.3.4 Belief in the clients' ability to heal

This theme refers to an attitude some of the participants named as important to have with the clients who are survivors of trauma. The participants who mentioned this topic acknowledged the complexities this attitude may entail because it may be confused with projecting expectations towards the clients. I present this theme here as an intervention which is similar to the above notion of acceptance, where the participants modelled intention towards recovery as a way to support the clients to engage and manage the therapeutic process.

P1, A BP from Canada, referred to a case of an adult female survivor of sexual abuse to illustrate the importance of holding the possibility that the client could have got better.

> *Holding the hope that things would be better and that there will be the possibility for her to… holding that hope that things would improve and that, I would also be there for her, and that there would be the possibility for her to go through this and, and, come out on the other side and… feel like herself again. (P1, p.17)*

This extract portrayed how the participant was holding a belief in the client capacity to heal in the form of hope, as they expressed it. I suggest that when the participant was intentionally sustaining the hope they described, it turned into a therapeutic attitude and in some respects, an intervention. Even though they did not, according to this extract, discuss that hope directly with the client, I argue that they consciously embodied it and consequently introduced it as part of their facilitation of the therapeutic process. Following analysis, I understood the mechanism of such indirect intervention as having the potential to have made an impact on the attitude of the client as well as on the dynamic of the relationship and supported the therapeutic process.

P9 (a DMP from Germany) discussed a possible tension that may result out of having belief in the client and cautioned against unrealistic attitudes towards the outcomes of the therapy; in doing so, this participant offers a slightly different perspective that separated the above mentioned hope from its materialised form as expectations.

> *One should avoid, easy solutions, and umm… avoid, going – I was going to say, avoid being too optimistic (laughs), but that's not really true, because of course, like, you have*

to exhume a lot of optimism, but, the point is to, not have too high expectations of the person. (P9, p.27)

This extract was useful during the analysis to highlight the difference between the notion of belief in the client and their capacity to heal, and between possible projections of expectations from the therapist in relation to the outcome of the therapy. I felt it was a subtle and yet material difference that was highly useful to name, particularly in the context of this thesis, which aims to clarify clinical practice and set the foundation for a trauma-informed framework. Following this extract, I suggest that belief in the client was used to model the possibility of recovery though self-belief and self-determination, similarly to the extract from P1. As suggested by P9, expectations from the therapist side may not have been supportive of the therapeutic process. I highlight the possibility that projecting expectations was likely to have little to do with the individual therapeutic process and stem from a variety of different reasons why therapists may wish for a successful outcome for the treatment.

P3, a DMP from New Zealand, gave some examples of self-doubt their clients experienced during the course of the therapeutic process. I added this extract to the current theme as I felt it gives a different approach to the belief in the client through a description of an active and direct intervention. This participant suggested that preparing the clients for the difficulties the therapeutic process may entail could support them towards preserving through it.

I do try to prepare clients to the fact that they will often feel like, here I go again, you know... so they can be self-compassionate, and curious about that, rather than think, oh, you know, or, it hasn't worked… I'm back where I've started! or whatever… so it's that kind of thing of preparing people to the fact that, there will be times when they'll go back to old material, or, they're not gonna manage to be different in how they, how they respond to things. (P3, p.8)

My understanding of this extract was that this participant, by directly articulating possible difficulties, was simultaneously re-enforcing their own perception of the clients as individuals capable of managing a difficult process. I propose that such an attitude has much potential for empowerment and that by thus directly addressing their clients, this participant evidenced their belief in their strength. Following analysis, I felt that the act of being open with the clients

regarding the potential challenges signified the therapist's trust in their capacity to manage, heal, and be capable of making informed decisions.

Similarly to the theme of acceptance, belief in the client's capacity to heal was introduced by the therapist both directly and indirectly and used to encourage the clients to believe in themselves. I pose here that the client' self-belief in their capability to heal is required for the maintenance of the therapeutic process, which subsequently relies on their motivation to engage with it. It may be likely that the clients have lost their confidence and self-esteem as the result of a negatively altered sense of self, and I suggest that in such instances, this may hinder engagement with the therapeutic process. The participants discussed different approaches to this theme, however, whether the above accounts related direct or indirect introduction of this concept, I understood it is important that the therapist will have embodied it, and truly believe that the clients are able to recover from the trauma.

4.4 The humble therapist

This superordinate theme refers to the instances of vulnerability and perceived errors found in the interviews and made by the participants in relation to their management and facilitation of the therapeutic process. This section also encompasses the ways in which participants were found to position themselves on an equal or lower footing than their clients, and in relation to knowledge and leadership of the therapeutic process.

4.4.1 Self-doubt

This theme stemmed from anecdotal accounts of where the participants related their perceived lack of therapeutic success and/or offered potential explanations as to why that may have been the case. The way in which those instances were related changed across interviews and differed from general reflections to specific case examples, through which the participants, I suggest, attempted to derive meaning of those incidents as inevitable experiences of clinical work.

In some cases, the experience of self-doubt and feelings of guilt were explicitly named. For example, P4 (a DMP from the UK who worked with survivors of domestic abuse) related a clinical incident where they shared their own embodied experience with the client as a form of

an intervention, rationalised by the idea of letting the client know they were being seen and heard by the therapist. However, this clinical choice was then accompanied by self-questioning and doubt regarding a possible unhelpful impact on the client and their process.

> *And afterward I thought, oh my god what have I done, this big emotion that maybe has nothing to with them that I shared with them … and for a whole week I felt very guilty, and I think I brought it to supervision… and the next week she* (the client) *came back and said, oh my god, you know, this has changed everything, what you said to me last week. (P4, p.22)*

In this extract, the participant openly shared an instance in which they doubted their professional judgment and questioned the motivation behind their clinical intervention. Interestingly, according to this participant the client seemed to have greatly benefitted from that intervention and therefore the account seemed to emphasise the need of the participant to trust their professional instincts. However, the material point extracted following the analysis is the experience of self-doubt which, according to the above, was strong enough to have stayed with the participant for a whole week and was brought by them to supervision. My understanding is that discussing such instances, be those of successful or unsuccessful outcome, is important to allow a conversation of clinical strengths and weakness as well as to normalise mistakes done in a clinical setting. I interpreted the above extract as the participant sharing their self-reflective process and while it concluded well in the present instance, there is nonetheless a reference to self-doubt experienced by this therapist.

Unlike P4, who accounted for the fear of making a mistake which turned out well, P6, a DMP from the US, rationalised the making of mistakes as a therapist and the potential benefit for it, as contributing to the therapeutic relationship and process.

> *If you do screw up – because let's face it, we're just human being, you know, so, there are gonna be times when we screw up! Umm, the best thing you can do is own it… be humble - 'I really shouldn't have said that', 'I really apologize', 'I would like to hit the rewind button, can you go there with me?' (laughs) - and to just be completely honest about it, because I also think that it's important for your client to see that you're human*

being too, cause you have to model what it's like… you certainly can't have your clients walking around thinking you're God… that's horrible… (P6, p. 29)

According to this participant, the possibility also existed to harness moments of perceived error in order to support the therapeutic process and enhance the relationship. In fact, it may have been the case that these moments in which the participant made an error and owned it were equally beneficial for the clients as the successful interventions. Following this, I propose that it may indeed be a realistic attitude. As P6 stated, human beings are prone to error occasionally, and professional training and clinical experience are no guarantees against making mistakes. Furthermore, what this extract highlighted is the possibility presented by this participant of utilising any frictions that may occur in the therapeutic relationship as means to further engagement in the process.

Contemplation of the challenging aspects of clinical practice, I understood the above accounts as signified the participants' professional integrity and reflective habits. However, important to name that not all participants related or elaborated upon their own perceived shortcomings as practitioners. I suggest that while there will be an understandable tendency to highlight one's strengths, an in-depth examination of perceived clinical errors in DMP with this client group can add much to the establishment of a trauma-informed framework, as it currently under-researched in existing literature.

4.4.2 Not knowing

This theme of not knowing refers to an attitude expressed by some of the participants by which ownership of the therapeutic process was seen to belong to the clients, rather than the therapists. This attitude emphasised that only the clients could have determined the course of the therapy, both in terms of understanding the meanings of their experience and in terms of the leadership of the therapeutic process. In discussing this topic, the participants were adopting a position in which they did not presume to know what was right for their clients, and while they contributed their understandings and offered interventions during the treatment, they insisted it was suggestive rather than assertive.

For example, concerning leadership of the process, P1, a BP from Canada, discussed their experience of knowing what is right for the clients (children and their families), and the idea that the therapist's sense of knowing did not always proved accurate:

> *Thinking back to the beginning… and it's really funny actually, when I really tried to help them (the clients)… what I offered to them wasn't very constructive. I had to learn to follow the clients and, their, their… and follow their body, because this is where they hold their wisdom. (P1, p.14)*

This participant accounted for the evolution of their practice and letting go of what may be seen as a personal involvement in the process of their clients. According to this, the thought of helping somehow interfered with the process, from the perspective of this participant. I questioned during the analysis if it may also be the case that this extract represented some tension was part of the development of the suitable work method for P1. What I deducted from this extract is that a less knowledgeable approach seemed to have helped this participant to better support their clients. Perhaps being in the not-knowing place for the therapist have enabled them to better follow their clients, and without introducing ideas and/or interventions that diverted the latter from their own sense of knowing.

Similarly, P8, a DMP from Germany and a private practitioner, related a case example of a female survivor of sexual abuse in which their own idea of what could have furthered resolution of trauma for a client was in fact not the right way for that person.

> *It was clear there was something she had to do with the mattress and I thought, she really had to- my image was that she's probably really- has to hit the- it was the offender, the mattress was the symbol for the offender and, and, I thought she might hit it...but when the time came, then she ripped the whole fabric apart... so that was interesting to see the clients have, such beautiful ideas, eh, and we shouldn't force them to do anything, and not even make any, any suggestions, you know, because I have this, aggressive thing, strong, in my head and she had it more delicate, by tearing it apart. (P8, p.18)*

This extract is, to my understanding, expressing the same idea as P1 did in the previous extract, and that is a need for the therapist to have held back on intervening in order to allow the client to creatively find their own path towards recovery. According to this, the participant suggested that their own inclination of what needed to be done, therapeutically, was not in accordance with what was right for the client. Furthermore, P8 seemed to have appreciated the difference between themselves and the client and held back on offering any solutions in order to allow the client to discover/create the intervention themselves. I understood here that it may have been essential for the therapist to be patient and adopt a position of a non-knowing place to create the space for the client to, finally, be able to act out what they needed to do by way of resolution. From this I propose that the concept of the therapist not knowing served this participant in a way that they were able to refrain from voicing their own suggestion which, in light of later developments, may have not been supportive of the client and their process.

P1, the above BP from Canada, also suggested an attitude that accounted for practical considerations in relation to having been in the not knowing position, while still retaining their trust in their own professional judgment.

> *Because it can be fine if I want them to… I think the best thing for them is… whatever, they're paying a lot of money to come to these sessions, like, it's not cheap! And so I think, ethically I think well, so, what's my opinion, but, at the end of the day, they're- they drive it! It's their space and they have to make those decisions. (P1, p.23)*

Here the participant did not dismiss their professional opinions and insights, but rather passed the responsibility onto the clients, to follow or reject given suggestions, for example. It is unclear from the analysis of this extract whether or not the participant did advise their clients about their own suggestions and interventions or not. However, it may well be they have indeed shared their own opinions and yet were able to step back when needed to allow the client to take leadership. The latter will have been a different approach to what was expressed in the other extracts in regards to being in a not-knowing place and yet it leads to a similar conclusion in my opinion. I regard the latter example as a solution for the participant to have contributed their notions and then to have stepped back and accept the clients' leadership. And I highlighted it

here that according to this, this participant perceived that it was their role to accept the clients' decisions even if it contradicted their own professional views.

This active withdrawal of the therapist from claiming knowledge of the therapeutic process was discussed by the participants in order to allow the client to actively lead their own therapeutic process for it to be fruitful. I also posit the potential implication of the therapist assuming a not-knowing position, whereby it may also enable the client to become empowered within the bounds of the therapeutic relationship, which in turn may enhance growth and subsequently support recovery.

4.4.3 Curiosity

Some of the participants, which coincidently were all DMPs, discussed their perceived importance of having a curious attitude for the continuation of the therapeutic process. They expressed the notion that having a curious approach to therapeutic exploration may have contributed to supporting openness and reducing judgment, both on the therapist and the clients' parts. Furthermore, it was suggested that when clients adopted a curious approach they found it easier to accept themselves and where they are at in the process.

P3, a DMP from New Zealand who worked with survivors of sexual abuse, suggested that a curious approach to be supportive of the therapeutic process for their clients as it may replace a more judgmental attitude.

> *So they can be self-compassionate, and curious, about that, rather than think, oh, you know, or, it hasn't worked, you know…I'm back where I've started or whatever. (P3, p.8)*

This extract highlighted a degree of frustration the clients of this participant may have experienced during and/or at different stages of the therapy. From this it may follow that some clients may have possibly underestimated the length of time as well as the magnitude of the processing of trauma. Therefore, these clients will have lacked realistic appreciation of the complexities that therapy inherent. According to this participant, the concept of curiosity may have been a solution to such challenges in so that it helped these clients to withstand the challenges of engaging with the process and increase their capacity for patience. The analysis of

this extract brought forth the idea that it may be the role of the therapist to introduce this concept as part of the therapeutic process to support the clients during difficult moments in the therapy. However, it was unclear whether or not this participant directly discussed this notion with their clients or whether it was indirectly embodied by the therapist and thus been made present within the relationship.

P4, a DMP from the UK, spoke of their own curiosity as guiding them through the process and referred to this concept as a personal attribute that was actively used as a tool with their treatment of this client population.

> *I might be very curious about something, I might be VERY curious (laughing) and ask questions… and I might have an emotional response for that as well, so… I will always try to own that and language that appropriately. (P4, p.17)*

Here curiosity was regarded by this participant as leading them in the course of the therapeutic process with their clients, as becoming curious was suggested by P4 to be an exit point for them for further inquiry. Furthermore, the notion of curiosity was also spoken of here as having an embodied component, in my opinion, due to the reference to the emotional responses this participant occasionally have had in addition to a perhaps more cognitive and/or/ content focused questions. Following analysis, I wish to highlight that the concept of curiosity as discussed in this extract may have links with notions of tacit knowing and intuition and relate back to the specifics of DMP practice. In other words, tacit knowing, or the knowing of something without quite knowing how it is known, is in my understanding connected with creative and embodied therapeutic work methods. However, and in relation to the previous theme of not-knowing I wish to contextualise curiosity as a form of tacit NOT-knowing, consciously used by this participant to further the therapeutic process without overriding the leadership and embodied knowledge of their clients.

P8, a DMP from the USA and in private practice, discussed curiosity as a concept they used to avoid getting entangled with their clients and within the context of the therapeutic relationship.

> *It just brought out the word curiosity… I think that, one of my driving forces is a huge amount of curiosity and, when you can get your own self out of the way, you can just*

remain almost purely curious… so that, you know, you don't get sucked in… you can easily – it's really easy to get sucked in with people who are highly traumatized. (P8, p.14)

Similarly to P4, this participant referred to the concept as a personal quality, an attribute they bring into their clinical practice and which they use consciously with their clients. An interesting point raised here regarding the idea of the therapist getting out of their own way, which I interpreted as the therapist putting aside their own expectations from the therapeutic process and from the client. This notion I saw as linking with an idea discussed earlier by P9 in regards to the belief in the clients' ability to heal, and the importance it has for the process for the therapist to have held back and refrain from having too high expectations of the clients. In the present extract, P6 was referring to a similar notion from a different perspective, and that related to the means by which a curious attitude may have been achieved for them. I pose that the two are interlinked, and it may have been the case that retaining curiosity supported this participant from becoming too involved in the process. As a result, and according to this participant, curiosity was also used by them to maintain the therapist's wellbeing as it supported the therapist in refraining from getting too personally involved with their clients.

Following analysis of these extracts I pose that curiosity was regarded a personal characteristic, made useful when consciously used clinically and in support of the therapeutic process. The participants also discussed some benefits curiosity may have had: for example, how its use allowed the therapist to take an inquisitive approach and prompt the client to explore new areas or topics. Considering the challenging nature of trauma-informed DMP, I suggest retaining curiosity as a therapeutic tool may have been a contributing factor that influences the therapeutic process, as discussed by the participants. I also highlight that embedding curiosity as in a DMP framework focused upon trauma may be relevant and add more scope to further clinical work. Implied by analysis of the above extracts, a curious attitude may require the therapist to avoid and abandon preconception regarding their clients and their decision-making process and instead use curiosity as an exit point for a clinical exploration and discovery of new therapeutic possibilities.

4.5 Summary

This chapter outlined findings that related the beliefs, ideas and self-perceptions of the participants as DMP and BP practitioners who treat survivors of trauma. The findings were gathered in three super-ordinate themes, each referring to a different area of clinically-oriented lived experiences accounted for by the participants. I present these themes here as supportive of a greater and in-depth understanding of what being a therapist with an embodied and creative orientation may entail, and specifically in relation to work with survivors of trauma.

Participants' background – The main theme concerning the background of the participants involved those accounts that discussed the therapists' *own experience of trauma* or the lack of it. According to the analysis, relating personal experience of trauma seemed to have represented an additional dimension in the capacity and related knowledge of the participants to carry out clinical trauma work. For those who referred to this topic, the embodied experience of trauma or its absence seemed to have impacted on their perceived professional capacity. Pros and cons were discussed as to the clinical contribution that traumatic history may have had for the participants, while those who have experienced trauma suggested that it enhanced their capacity to treat this client group. However, the participant who discussed not having had a history of trauma suggested a multifaceted perspective to this theme where they proposed that both the experience of trauma and its absence were equally advantageous in relation to clinical practice. The implications of this topic to trauma-informed DMP lies, I propose, in perceiving the embodiment of trauma as a source of knowledge and in particular in relation to experiences of recovery from posttraumatic symptoms. In other words, a therapist who recovered from trauma has a strong claim to varying degree to support others through a similar process. On the other hand, the experience of embodied wholeness where trauma did not occur may be an advantage of a different type, which was indicated as valuable by the findings presented here. I suggest that this theme indicates that the history of the participants (either of trauma or its absence) was perceived as material in shaping their practice and enhancing their clinical capacity.

The role of the therapist – The analysis indicated this cluster of themes might represent the desired attributes the participant highlighted as useful for clinical work with this client group. *Resilience* as a professional attribute serves to illustrate the capacity of the therapist to manage

clinical trauma material and was suggested as a key factor that requires further consideration and investigation in the context of trauma informed DMP. Resilience to manage clinical trauma material was highlighted as being supportive of the therapeutic process as it enabled clients to build trust in the therapeutic capacity of the participants and their ability to withstand details of the trauma. However, little reference was given to the means by which resilience may be developed and enhanced. Furthermore, limited discussion was offered about the embodied implications of resilience or its relevance to DMP as a therapeutic concept using this client group. I suggest that further research will be useful to examine and better understand clinical resilience from a DMP perspective and in the context of trauma-informed practice.

Another concept that was mentioned by some participants is *caution*, as particularly relevant for clinical work with this client group. For example, caution was recommended in regards to the use of touch in the context of DMP and BP and in relation to embodied interventions. The participants highlighted the use of touch as relevant to DMP use of body and movements as interventions and which, according to the analysis, may be a trigger to clients with a history of trauma. As such, caution regarding touch was recommended by the participants and more particularly when working with survivors of sexual abuse. However, some participants argued in favour of some use of touch, given the right circumstances, while still emphasising the need for caution. Therefore, this finding emphasises the need for much consideration before utilising touch as an intervention with this client group. I also highlight caution as a finding in a broader context, where caution in treatment of this client group is one in consideration of managing triggers as a posttraumatic effect. More specifically, as suggested by the literature memories of the trauma may be triggered by almost anything and everything (e.g. sounds, smells, key words) due to the individualised experiencing of traumatic experiences. Therefore, the need for cautious DMP practice may support a conscious identification of potential triggers as part of the therapeutic process, to avoid any overwhelming re-experiencing of the trauma during sessions.

The theme of *acceptance* was discussed as considering the clients from a non-judgmental perspective that was both beneficial for the development of the therapeutic relationship and perceived to have supported clients' acceptance of themselves. For example, one of the participants suggested that framing posttraumatic symptoms as normal responses to adverse situations was helpful for reducing the clients' sense of guilt, self-blame and exclusion. I further

suggest that the importance of this concept also lies in its contribution to the therapeutic relationship, and participants highlighted that accepting their clients enabled the latter to trust and accept the therapists in a reciprocal process. Finally, *belief in the clients' ability to heal* was the last theme in this group, representing a type of motivation offered by the participants, in particular at the moment of the therapeutic process when the clients did not have that belief in themselves. Therefore, the participants asserted that the role of the therapist includes holding that belief, or the hope, that the clients will indeed find a way to recover from the trauma. However, a distinction was observed by one participant between belief in the client and having unrealistic expectations in regards to the results of the therapeutic process. Therefore, I frame this finding a provisional theme that is similar to acceptance and yet needs further consideration generally, and particularly in the context of DMP. Best on the data, it is unclear what the embodied and creative implications of acceptance are as well as the belief in the clients, and how they may be specifically relevant to a trauma-informed DMP framework. While I deemed both as attributes that were embodied by the participants as part of their perception of themselves as therapists who treat survivors of trauma, the implication of these qualities for the DMP clinical practice, as well as training, requires further elucidation.

The humble therapist – According to the analysis, the last group of themes in this category represented an attitude of humility seen through the participants' accounts participants of their own doubts and limitations of knowledge. *Self-doubt* was discussed from different perspectives and was identified as a means to question as well as validate clinical choices, as in some examples given: the need for self-doubt turned out to be unfounded. This approach to communication of clinical experiences may be useful for further exploration, as there was a possible tendency of the participants focussing on 'success' stories and avoiding relating more challenging incidents. According to the analysis, I suggest some of the adjustments to current culture may support further development of trauma-informed DMP practice. More specifically, I argue that acknowledging and better understanding the challenges and hindrances that DMP practitioners face when treating survivors of trauma may be key to improving current practice and theory, and be equally important as the factors that directly further recovery. A different perspective of this theme, however, asserts that 'mistakes' made by the participant were inevitable and at times facilitated the therapeutic process by introducing the therapist as a human (i.e. someone who may make mistakes) and potentially strengthening the therapeutic

relationship. Therefore, there is an aspect of self-doubt that may be harnessed and utilised to further the therapeutic container, when used consciously and deliberately.

Not knowing as a theme was discussed by the participants in the context of leadership and of the therapeutic process and referred to a perceived understanding that the clients were the best leaders of their own recovery. From this, it implied that is was advisable for the therapists to refrain from having an overly directive approach. For example, some participants highlighted it was more productive for clients to utilise their own problem-solving capacity than for the therapist to intervene by suggesting solutions or advice. I understood this theme as concerning an attitude adopted by some of the participants and by which they offered interventions and suggestions according to their better judgment, while conscious that these may not best suit the clients and their process. As a consequence, this was perceived as enabling a mutual process of empowerment and potentially elevating the therapeutic relationship through the space the participants made for their clients to own and make meaning of their process. Therefore, I propose that adopting a not-knowing attitude was potentially useful for the participants in their work with survivors of trauma. However, further investigation is required to better evaluate the impact such an attitude will have had on clients and in the context of the therapeutic process. For example, examining the data does not clarify the levels of guidance that were useful to the clients of these participants.

Finally, the last theme in this category was *curiosity*, which was also found to have some links with the theme of *not knowing*. The participants spoke of curiosity as a concept that was utilised to enhance a non-judgmental approach, which in turn was perceived as a clinical tool used to navigate through the therapeutic process. Curiosity was discussed as valuable by those participants who named it, in so that they were able to use it consciously to support their clients. For example, the curious approach was discussed as helpful to avoid from prejudice regarding the clients, whereby projection may have resulted and hindered the therapeutic process. The analysis revealed that curiosity was embodied by those participants and was, similarly to the attitude of not knowing, embedded in their practice and used on a regular basis. However, as was the case with the previous theme, the specifics by which curiosity is applied in DMP are at present unclear.

As seen above, some themes have had a clearer relation to DMP than others and where that was not the case I have highlighted the need for further investigation. However, I also suggest that some themes emerged as principles rather than more concrete interventions, and I therefore regarded those as possible guidelines that are potentially highly transferable. It would have been useful in the context of this thesis to have more extensive examples illustrating embodied and creative interventions. However, I argue that due to the current state of the art I deem the intangible concepts as highly useful for this thesis, with the aim that further elucidation of their meaning in the context of DMP may be carried out in the future.

5 Findings - The Client

5.1 Introduction

The findings presented in this chapter examined the participants' understandings of their clients as survivors of trauma along with manifestations of trauma effect, and perceptions of clients' self-management and engagement with the process. The super-ordinate themes (and clustered sub-ordinate themes) found in Table 4 represent the meanings that emerged from analysis of the interview transcripts which regarded the participants' understandings and perceptions of their clients as survivors of trauma. The participants discussed their experiences and perceptions of their clients, and I used my interpretation to identify patterns and highlight meaning while guided by my ontological and epistemological approach. Extracts from the transcripts of the interviews are presented here to ground the findings in the participants' original and individual narratives. I propose here that investigating the ways by which the participants regarded, considered and reflected upon their clients in therapy highlighted an additional dimension to DMP and BP in the context of treatment of trauma that may have not been explored to date.

Table 4 - The Client: Abstraction of themes

Cause and effect of trauma

- Causes of trauma
- Trauma and embodiment
- Dissociation
- Posttraumatic symptoms
- Triggers

Hindering factors

- Posttraumatic identity

Supporting clients' engagement with the process

- Clients' individuality
- Clients' ownership of the process
- Positive change

(Note: Super-ordinate themes marked in bold)

5.2 Cause and effect of trauma

Overall, the participants' different areas of clinical expertise encompassed clients with a wide range of traumatic histories. Differences in the terms used to define client populations is a possible result of preconceptions that may be influenced by culture and language as well as employment, education and professional training. Part of the analysis was to ascertain whether or not overlaps of clinical practice existed. In other words, during the analysis process I considered the possibilities that the participants may have referred to, for example, a similar client group or accounts of the effects the trauma has had on survivors, but using slightly different terms. According to analysis, it has mainly been the case that the terms were similar and more commonalities then differences were found in the clinical experiences that the practitioners described.

5.2.1 Causes of trauma

This theme refers to the participants attempting to define and differentiate between types of trauma according to the original event(s) and their lengths. While the majority of participants named sexual abuse as the most common cause of trauma seen in their clients, some made a point of emphasising other life circumstances as potentially resulting in trauma.

Those participants who named sexual abuse as a common causality for trauma they had seen with their clients named it without going into much detail. It appears that sexual abuse is a circumstance commonly agreed upon to result in trauma to such an extent, that little explanation is needed. For example, P3, a DMP from New Zealand, referred to this causality in a very brief statement, suggesting that:

> *Most was sexual abuse trauma, childhood sexual abuse. (P3, p.1)*

Later on in the interview this participant shared that in New Zealand survivors of childhood sexual abuse are entitled to funding from the government to receive personal therapy (P3, p.6). As context, this funding will increase the availability of treatment for this client group and as a result, could be a culture-specific variable that impacts on the specifications of clients approaching this participant. From a different perspective, another example can be found with P8, a DMP from Germany who practiced privately and was very succinct when referring to traumatic histories seen with their clients:

> *I would say the highest percentage is sexual abuse. (P8, p.2)*

Now, this participant was involved in both a government-funded clinic that received referrals from primary care services as well as their own private practice (P8, p.2). From this it can follow that the clients seen by this therapist are of diverse socio-economic backgrounds and will have arrived at treatment through different channels. Nonetheless, despite the seeming diversity, according to this participant sexual abuse is suggested to be a common trauma causality. Therefore, despite the difference in context and experience, I highlight this notion as a potential pattern.

As well as sexual violence, P4 (a DMP from the UK who worked for a charity organisation) also named divorce and separation as causing trauma for children:

> *I was with young children whose backgrounds were very traumatic or, if you think of trauma as, which I do believe your parents splitting up is, these were children that from a young age had events that were, traumatic. (P4, p.2)*

This example serves to emphasise the broad range of circumstances which can result in trauma, as well as the difficulty in defining those. It can be hypothesised that for some children the separation of their parents may be experienced as traumatic while for others it will indeed be difficult to make sense of, and yet their perception of themselves and/or the world will not be negatively altered, therefore not resulting in trauma. This example supports a phenomenological conceptualisation of trauma and posttraumatic effect as rooted in the survivors' perception of their lived experience and its meaning, rather than in some 'objective' circumstances.

A common attitude among the participants towards differentiating types of trauma seemed to distinguish between single and multiple traumatic incidents. Contextually, the participants discussed this distinction mainly as relevant to treatment considerations: namely, the approach appropriate for treating a single incident trauma as opposed to the one used to treat survivors of long-term abuse. P5, for example, a DMP from Finland who practiced at a hospital, made a comparison between a single incident trauma and long-term abuse, with reference to treatment implications.

> *For example, if it's only one single issue, like a car accident, in your adulthood, and otherwise your life has been quite safe, that might only be one time that we need to do this kind of work, but if there is a, like a long lasting early trauma, from your childhood... where you have had lots of different situations, then this kind of work needs to be done many time. (P5, p.17)*

This example indicates that the length and type of trauma would have been an influencing factor for this therapist in their choice of interventions. From this it can follow that, evaluating the needs of clients can be done based on the length/frequency of the trauma experience rather than the circumstances in which the experience took place.

Overall the participants suggested that the type of trauma is an important consideration for treatment and referred to this concept from a practical rather than theoretical perspective. It is important to highlight, however, that the discussion of types of trauma tended to refer to length and frequency of traumatic events rather than to their cause. I propose that this tendency indicates that, as far as treatment consideration goes, the circumstances of the original trauma were seen by the participants as secondary in comparison with factors such as chronic repetition and the age of the survivor at the time, for example. Examining these extracts, I concluded that while some circumstantial categorisation was taking place in practice, the participants suggested they had assessed the needs of their clients individually. As articulated by P2, a BP in private practice in the UK, *"it depends on the problems presenting, how I would work." (p.4)*. At this stage it is difficult to ascertain whether this attitude is based on clinical personal preferences, specific theoretical frameworks or influences from training programmes. It may also be that limited literature and lack of established links between trauma histories and specific interventions have rendered a case-by-case assessment approach.

5.2.2 Trauma and embodiment

In the interviews, the client's body was often referred to as the bearer and keeper of traumatic experiences whether or not the client had clear and conscious memory of the trauma history. The participants discussed different understandings of the embodied effect, or mechanism, by which trauma may be experienced. These accounts, I believe, reflected the theoretical affiliations of the participants as well as hinting at their approaches to practice, including bodied aspects of treatment, trauma processing and releasing posttraumatic stress stored in the body. Most participants referred to the idea that trauma can be observed in the clients' bodies, that noticing it can be used in treatment.

P2, a BP based in the UK, referred to the nervous system as the main physiological area affected by trauma which will have had subsequent impact on the rest of the body.

> *Mainly the nervous system is affected, that's what I'm trying to say, and afterwards, the longer the posttraumatic stress goes on, the more the immune system gets affected, and you get ill all the time... I had some clients who just got ill all the time, with all kinds of things. (P2, p.2)*

Similarly, P1 (a BP from Canada who worked with children and their families) noted they have observed the presence of trauma as residing in the muscles:

> *And it's like, you can see the tension in their bodies and it's like the body, the muscles still carry some of the fight or flight energy that was never resolved. (P1, p.3)*

These examples suggest an anatomical and neurological conceptualisation of trauma effect, rather than a cognitive or an emotional one. The trauma is seen as trapped in the physicality of the body and this notion may influence an embodied approach to treatment, or it may suggest specific theories that influenced these participants' practices. This attitude seemed to be present with the BPs among the participants while the DMPs had a slightly different and more integrated approach to explaining mechanisms by which trauma is embodied and impact the person.

P7, a DMP from the UK who worked with clients with addiction issues, discussed the mechanism by which trauma is embodied as unavoidable, an inevitable result of difficult life events.

> *I strongly believe that... All of the trauma is just held in the body, just been - blocked and - I mean, how your whole body has been invaded by abuse, physical and mental, and it just so deeply in the tissues. (P7, p.26)*

The reference to the traumatic memories as being located in the body tissues may suggest a conceptualisation which accounts for a connection between body and mind and which exceeds more neurophysiological perceptions of the effect of trauma. P3, a DMP from New Zealand and in private practice, observed that:

> *So, my experience is that most of the material that the person is avoiding is sitting in their body. (P3, p.15)*

This participant did not specify where in the body they often see clients hold traumatic memories, i.e. muscles of nervous system, but rather presented a more psychodynamic approach which might also suggest their theoretical framework. Through this extract it is possible to see a meeting point between psychodynamic psychotherapy and DMP, the former suggested by the

reference to avoidance, while the participants accounted for the body as the main exit point for treatment, as well as the scene of the trauma.

P9, a DMP from Germany who worked with survivors of abuse, illustrated their own perception of clients' embodiment of dissociation through consideration of their movements, and then using these observations for further clinical exploration.

> *Certain body parts are taboo, or they have certain postures or behaviours that are part of, what they've experienced, like one women said she had had to hold something under her arm, you know, under her armpit, and then sort of her body was like this, and then she always moved like this! And these kind of things when people have strange movement patterns… And then if you explore what's behind it there might be some kind of relation to that (the trauma – C.G). (P9, p.4)*

This example, unlike the previous ones, suggests that this therapist is assessing and evaluating the impact of trauma upon their client as and when they are expressed in movement and body postures. The difference from previous extracts lies in the practical and applied example given by P9 and which may be more applicable than the slightly more theoretical conceptualisations used by other participants. I understand this extract to be a tangible example of how traumatic memories can be held in the body and a DMP-specific means of assessing that which is physically visible as a possible manifestation of traumatic memories.

Through examining these extracts I began to see the different ways in which participants recognised the effect traumatic experiences and memories had on the clients, both in body and in mind. Moreover, embodied therapies seemed to penetrate clients' defences in ways in which the issues were made immediately available through observing the body and perceiving it as the landscape where the trauma resided and was embedded.

5.2.3 Dissociation

Dissociation as a coping mechanism and posttraumatic effect was discussed by some of the participants and was mentioned with regards to physical as well as emotional aspects of the term. It seems that dissociation as a posttraumatic symptom was regarded by the participants in

relation to its embodiment and impact upon the bodies of their clients. This theme is presented here as portraying another aspect of understanding, and as part of the clinical and professional meaning-making process of the participants.

P9, a DMP from Germany who is experienced working with survivors of sexual abuse, described the mechanism by which clients dissociate from their bodies, with emphasis on the embodied component of dissociation. According to this participant, during the trauma survivors disconnect from their body and leave it behind to experience the event while drifting away from the scene of the trauma.

> *At this phase where the actual trauma occurs and the person dissociates into, you know, eh, floating up onto the ceiling and watching themselves and at that point, also sorts of sensory stimuli gets captured in the memory of the, the body and the sensory system. (P9, p.6)*

This example illustrates the dissociation process from an embodied perspective, where a split is formed between the person and their body. With this, the participant highlighted what happens when the dissociation mechanism occurred, which resulted with the traumatic impressions being stored in a sensory form. My interpretation was that this extract described dissociation as a survival mechanism by which the body is left behind to absorb the impact of the traumatic event while the cognitive/emotional parts disconnect on account of being overwhelmed by the experience. I believe this also hinted at the way by which posttraumatic symptoms may develop, as according to a previous extract from the interview done with this participant and which was presented earlier, the traumatic memories remain present in the clients' physicality and are detectable in their movements.

Another DMP, P3, who was based in New Zealand and was in private practice, also explained dissociation as a disconnection between the person and their body:

> *I would say that trauma and dissociation, kind of... distance people, I find, distance people from their sense of their body and their ability to do things like regulate their breathing, and... Reduce anxiety. (P3, p.5)*

Unlike P9, who mainly focused on the mechanism of dissociation, P3 discussed here the impact and possible implications dissociation may have for the clients, and in the context of movement and body work. According to this participant, dissociation has both physical and emotional/cognitive negative implications, whereby the capacity of clients to regulate themselves has been reduced. I understood this notion as representing a possible hindrance to the clinical practice of DMP with survivors of trauma, as disconnection from the body will potentially impact the ability of clients to engage with embodied therapeutic work. However, I posit it is also a reason why it may be important to survivors of trauma who incorporated dissociation into their self-management patterns. I hypothesised that creative engagement with movement and body work may have much value for this client group precisely because such work often results in enhanced connection between the different parts of the person, as well as greater body connectivity.

P7, a DMP from the UK who worked with clients with history of both sexual abuse as well as addictions, described dissociation in further detail and unlike the previous two participants, used some tangible examples they observed with their clients during sessions.

> *A strong symptom is dissociation, I see a lot of people drifting, you know, or absent, they're there in body but they're minds are constantly seeking some form of escape, eh... yeah, you often see it in the eyes, you know, they're there with you but they're looking elsewhere at interval, umm, a lot of them actively seek to heighten the dissociation through drugs and alcohol, but I see a lot of, young children or adults plugged into their phones, seeking out music which takes them away from - whatever's there. (P7, p.4)*

This participant's way of discussing the concept of dissociation differs from the previous two in that they refer to case studies rather than to the principle and conceptualisation of dissociation. It is difficult to say why that is the case, but I suggest it may be a factor of length of experience – when the interviews were conducted, P7 had been practicing for approximately four years, while P3 and P9 had been doing so for 20 years each. Interestingly for me, the account of the less experienced practitioner seemed more applicable and transferable as a result of the details and examples, as opposed to the other two, who seemed more theoretical. I see this latter example as referring to dissociation as posttraumatic effect, where clients can use simple and everyday

means to dissociate themselves, though it may not appear as dissociation. In terms of the implication for practice this extract conveyed, I emphasise body-based observations such as noticing of changes in eye movements and body postures that may be used by DMP as well as BP practitioners to identify moments in the therapy where the client may be dissociating.

Overall, the DMP participants who referred to dissociation did so in the context of body and/or movement work, and I propose it is a link from DMP theoretical framing which regards the body as central to this practice. The participating BP practitioners did not mention dissociation specifically and therefore it is not possible to suggest differences in conceptualisation based on modality or approaches to treatment. However, based on the extracts that concerned this concept I follow the notion that trauma can be present in the bodies of the clients and dissociation is an attempt to reject the trauma on the clients' part. Despite the fact that dissociation may make an embodied therapeutic process more difficult, I feel that these understandings argued for DMP interventions with this client group, precisely because creative movement can support body connectivity and processing of difficult memories stored in the body.

5.2.4 Posttraumatic symptoms

The main areas of posttraumatic symptoms mentioned by the participants were anxiety and self-harm, physical symptoms including chronic pain, and behavioural/embodied symptoms, such as substance abuse and eating disorders. Most participants named but did not elaborate on the methods they specifically use to treat these symptoms and/or areas of trauma effect. From a contextual perspective, I wish to highlight that during the interviews I did ask the participants to name common posttraumatic symptoms (see Appendix E) and the responses to that were similar across the interviews and often took the form of a list of posttraumatic effects. However, some participants did offer an in-depth discussion on the possible meanings the experience of these symptoms held for clients.

P1, a BP from Canada who had much experience working with children, noted that:

> *With children it's quite often problems with emotion regulation and arousal regulation, lots of impulsive behaviour, sometimes violent behaviour… (P1, p3)*

This observation may have hinted at neurophysiological theories that links attachment trauma with decrease in the capacity for effect regulation and as a consequence, a common posttraumatic effect. However, I did question during the analysis the inclusion of items such as impulsive and violent behaviours as posttraumatic symptoms with children, simply because I believe children may behave impulsively without it being rooted in negative experience but as part of their healthy development. Furthermore, this participant did not state the ages of the children they referred to and I feel there will be a big difference in what classified as impulsive and violent, dependent on the age of the child. P5, a DMP from Finland who specialised in attachment trauma, distinguished between symptoms seen with children and those observed with adults:

> *With some children it's more like withdrawing from relationships, not being able to engage socially with their peer group… then of course a lot of somatic symptoms, especially with my adult clients which are mainly sexually abused in their childhood, they have lots of different kind of pain in their body, sometimes they don't feel their body, and also big problems with self-regulation. (p.2)*

Here too, I wish to highlight, that while this participant is differentiating symptoms seen with children and with adults, withdrawing from relationships with peers is a symptom that can be seen with adults and may be referred to, for example, as social anxiety. Perhaps this participant made the above suggestion based on their own observations, where children are more easily seen and their behaviour is reported by the adults in their lives (parents, teachers), while behavioural information about adults is likely to stem from self-disclosure. Nevertheless, these two practitioners highlighted possible behavioural and emotional aspects resulting from trauma, as well as physical, and I suggest that in effect what was discussed here relates to the reduced ability to self-regulate as well as to self-contain.

Fear as a result of trauma seemed to be referred to in greater length than other symptoms and the participants described how often their clients experience fear and anxiety throughout their daily lives. P2, BP from the UK and in private practice, discussed social phobia and anxiety when referring to clients' posttraumatic fear while making a link with the idea that trauma can negatively alter clients' sense of self:

A lot of people might be quite afraid to go out of the house, afraid to see people… they're just not their old selves. (P2, p. 8)

According to this extract, clients were seen to be impacted from the trauma to such a degree that their lives were dominated by the experience of fear. Furthermore, following an analysis of this extract, I link the experience of fear with the loss or alteration of these clients' sense of self, whereby the world was no longer safe or secure enough for them, which is perhaps why they chose to not leave their homes. From a slightly different, broad and more general perspective, P4 (a DMP who was also based in the UK) referred to fear as a primary posttraumatic symptom.

I think fear, fear in various forms and shapes… that would be THE most common symptom... some would react more somatically, in terms of physical symptoms like digestive problems… others will have insomnia, nightmares which are partially somatic, partially psychological. (P4, pp.1-2)

This participant seemed to have positioned fear as the root experience for subsequent posttraumatic symptoms, physical and psychological. I would like to note here that while anxiety is considered a prominent posttraumatic symptom in the literature, fear is not seen as a symptom, or at least it is not discussed as such professionally. However, what the two extracts above suggest is that perhaps fear as a symptom has not been investigated or incorporated into considerations of trauma treatment and is certainly not as often used as the term anxiety. Following the analysis of the above I suggest that it might be appropriate to regard anxiety as a manifestation of intense experience of fear and a symptomological result of it, and that the two are indeed embedded in the context of trauma work.

Overall, some symptoms seemed to be more prominent than others in the participants' views as they chose to discuss these in more depth and therefore emphasised those above other symptoms. I see this distinction as signifying some importance in regards to treatment considerations, and in the context of BP and DMP, clinical treatment of trauma. The highlighted and discussed symptoms, identified here as fear and reduced self-regulation, may need to be more specifically considered when utilising embodied and creative methods for the clinical work with this client group. Following the analysis of the above extracts I found that an aftermath of trauma can be seen in an enhanced and permanent sense of danger and threat in the

clients' lives. It is also important to note that individual responses to this negatively altered sense of reality can greatly vary and therefore identifying the source of the symptoms (i.e. fear) may be highly useful for treatment. I highlighted the latter notion in the context of clinical practice, because identifying the root cause of a given symptom may influence the choice of intervention utilised in treatment. Further discussion of fear and reduced self-regulation from the perspective of embodied and creative methods and their impact on clients may be useful to further current DMP clinical practice.

5.2.5 Triggers

The participants explained the concept of triggers as incidents in everyday life that through direct or indirect relationship with the original trauma evoked posttraumatic responses (such as anxiety, flashbacks and re-experiencing).

For example, this concept was discussed by P4, a DMP from the UK, in relation to the embodiment of trauma and traumatic memories and in the context of their clinical practice with survivors of domestic abuse.

> *A lot of the time people who suffered from physical violence from somebody are scared of particular movement qualities… and that (experience of/exposure to these qualities – C.G.) might trigger them consciously or unconsciously, they might be aware of that or not… but their nervous system might react to that. (P4, p.19)*

According to this extract, this participant, referred to triggers as the embodied aspects of the trauma effect, which may or may not be recalled by the client. This assertion may link with notions discussed in the literature regarding traumatic memories that can be triggered into being re-experienced through a specific and individual set of stimuli. This extract denotes an understanding of this concept as it may have appeared in a DMP session – that is, through the exploration of movements and their qualities and through which an embodied traumatic memory may be resurfaced. The inclusion of the nervous system as a factor in the mechanism of triggers getting evoked is an example of considered trauma-informed neurophysiology in DMP, and in this instance it is indeed done to explain the pathological mechanism, rather than inform an intervention. In relation to DMP clinical practice, what I deduct from this extract is that these

embodied triggers can be evoked spontaneously and perhaps also unexpectedly during therapy sessions, bringing to the surface unconscious and/or hidden traumatic material.

A similar observation was made by P1, a BP from Canada with experience of working with children and families, who suggested that different embodied cues can become triggers due to sensory aspects of experiencing trauma:

> *For example some postures, some activities that fully incorporate your body, some movements might, might remind you of the trauma experience, and will then activate something, like pieces of memory that you were not, eh… not been able to, see before. (P1, p.10)*

Again, similarly to P4, P1 discusses the concept of triggers while including the possibility that those may be unconscious and unknown to the clients. Here too, as in the previous extract, the triggers were suggested to be made conscious through body work. In some respects, what this participant may have been discussing are the notions of suppressed memory, or else this extract may be relating to some form of dissociation and disconnection between body and mind. In either way, following an analysis of this extract I again posit that embodied methods of clinical work seem to hold much potential for the accessing and identifying of triggers, and through those, the identification of unconscious traumatic memories.

A possible work method to manage triggers was discussed by P5, a DMP from Finland experienced with attachment trauma, who suggested that identifying the triggers should be done at the onset of the therapy, and as part of the therapeutic process.

> *And that's something we also need to learn together with the client, which might be those triggers in the body level, for the client… so in the beginning, it's also a lot of becoming aware of those triggers, which, which might eh, activate those reactions and symptoms, which might be related to how we use the body, how we… what kind of movements, we are, doing and so on. (P5, p.10)*

According to this, the participant suggested embodied and creative methods to incorporate this notion of identifying triggers in trauma-informed DMP. I suggest that making conscious links

between the movements and their qualities, for example, or sensations and postures, as well as posttraumatic responses and memories, may be a potentially tangible and transferable intervention. What I have also perceived in this extract is that through the mutual identification of triggers at the body level, the clients of these participants may have begun to increase their self-awareness through that action of paying attention to the embodied manifestation the trauma has had on them.

From an ongoing consideration of treating survivors of trauma, P7 (a DMP based in the UK) described case examples of how triggers occurred during sessions with their clients who struggled with substance misuse, and in the context of utilising relaxation exercises.

> *Or, lying on the floor, be allowed to lie there and they're like, oh no! Or - we're told we're lazy if we do that (lie on the ground – C.G.) or, or just lying about the floor has connotations from their past. (P7, p.8)*

This participant suggested they do not use relaxation exercises in the early stages of the therapy because it seemed to potentially trigger traumatic material with their clients, deeming the exercises as often unhelpful and at times even anxiety-provoking. Following analysis of this extract I wondered if this notion of relaxation exercises as a questionable intervention with this client group can also be extended beyond the original context of this participant's practice specification to include survivors of sexual abuse or torture, for example. This also corresponds with the other extracts above whereby it referred to the notions of certain postures can be triggering traumatic memories: for example, lying on the floor, as clearly highlighted by P7.

P9, a DMP based in Germany, expanded the above ideas by discussing interventions which may be less useful or appropriate for clinical work with this client group, with emphasis on the conceptual use of props and music.

> *As a dance therapist, it was also important to know that, certain props are a problem – things like ropes, umm… balls were usually ok, but sometimes if you work with scarves – various props can have a triggering function, and also music, was often difficult – this population will often have to work without music, because the chance that someone was*

going to go off into dissociation because of the music that was being played was too great. (P9, p.5)

When discussing the possible effect music can have, this participant was referring to group work and the difficulty of using music that matches the preferences of all group members. On this note I believed that the case might be different when working on a one to one capacity, where there are only the needs of one individual client to account for and the use of music may be beneficial and part of the therapeutic process. This extract corresponds with discussions of this concept made by other participants. The notion of use of props is again similar to considerations of posture and movement discussed by other participants as holding the potential to be exit points for clients to experience triggers. However, unlike the previous extracts that I see as transferable between DMP and BP, this latter participant spoke of methods which are, I felt, fairly specific to DMP practice. Nonetheless, overall I extracted from the discussions made by the participants a need for caution when utilising creative and embodied methods with this client group and that is uncommon in professional literature. Therefore, I felt that this theme was potentially and particularly valuable for DMP and BP trauma-informed practice.

In short, examining the participants' reflections and understandings of the concept of triggers I identified two main themes that I felt were discussed with regards to treatment considerations and implications. First is the notion that triggers often had an embodied component due to the trauma having been experienced through the body. This notion was followed by examples of the different ways in which to be mindful of and work with those triggers to facilitate and enhance the therapeutic process. Secondly, two of the participants, both DMPs, cautioned against the possibility of evoking triggers unknowingly during the course of the treatment and through the use of specific interventions, such as relaxation exercises and props, for example. I have seen this caution as highly useful recommendation for future investigation that will enable a more trauma informed use of specific creative and embodied methods. However, I also wish to highlight the approach which posed that triggers were being consciously sought after and identified to avoid unconscious activation of defence mechanism. According to the analysis, I concluded that in relation to clinical practice the two themes can perhaps complement each other in so that conscious identification of triggers is done throughout the process and on an on-going basis, and from a cautious attitude. At this stage of the research I believe that such an attitude

could be used to increase clients' self-awareness and sense of autonomy through better understanding of their own triggers while use of caution support the development of the process and is not hindered by unconscious acting outs, caused by triggers.

5.3 Hindering factors

This theme refers to the elements that were observed by the participants as having had interfered with their clients' therapeutic process. Notably, the participants did not stress these factors were always involved or needed to be considered, and they did not suggest that all clients will have presented with either. However, in response to my questions asking about factors that might hinder the process, these notions were suggested by the participants as relevant, and based upon their clinical experience.

5.3.1 Posttraumatic identity

Some of the participants suggested that their clients were occasionally seen to have had an unhelpful attachment to the trauma experience. According to some of the participants, this factor seemed to be more likely to occur when there was chronic repetition of the trauma and/or when there has been a long gap between the trauma and the engagement with treatment. In other words, the longer in the past the traumatic experience took place, the higher the chances were that clients may have incorporated the traumatic experience in their identity. Participants observed that in these situations the treatment may be hindered due to the fact that the posttraumatic sense of self, as well as the symptoms, have been embedded and integrated in the everyday lives of the clients.

P4, a UK-based DMP who worked with survivors of domestic abuse, discussed the notion of posttraumatic identity as a consideration for treatment and offered it as a possible explanation why for some clients this factor may have proved to have hindered their process:

> *If a person's sense of identity really solidified around the traumatic symptoms... So if their sense of personal identity, or ego is absolutely dependant on these symptoms, then change… and also all their personal life, relationships… then change can be almost unattainable… it seems that, I mean this is my experience, it seems that people who*

identify very very strongly with their symptoms were not open to change. They might feel better, BUT, they were not open to change. (P4, p.9)

This participant was referring to their work with clients who experienced domestic abuse, where the psychological and the physical violence were often integrated. Due to this, the clients of P4 were physically hurt on a fairly regular basis and in need of long-term primary and secondary care. Therefore, this client group may be considered as having unique needs in relation to treatment of trauma, as a result of the overlap between the physical and psychological and where the somatic issues hinder the capacity of clients to function in the world. I linked this extract to the present theme, whereby if the notion of having decreased capacity to function has been integrated with clients' self-definition, it may be a challenge to treatment. As P4 suggested, these clients struggled to achieve changes in their lives and/or their psychological/emotional patterns.

As a possible explanation to the creation of posttraumatic identity, the following extract is drawn from the interview with P3, a DMP from New Zealand, in relation to clients who survived childhood sexual abuse. P3 suggested that potential attachment to posttraumatic effect may be rooted in fear of not being able to receive professional support otherwise.

If the person got a personality disorder, or, if there's, umm, secondary gain, in having the trauma symptoms, you know, if there's fear of... I do find that some trauma survivors there's a fear of, if I, if I am seen as too functional I won't get support anymore. (P3, p.9)

This participant referred here to both financial and emotional support given to less functioning individuals in Western society.

Because I think, you know, culturally we tend to support people who are vulnerable and not support them when they're not. (P3, p.10)

For context, I will also add that this participant spoke elsewhere about the welfare system in New Zealand where survivors of sexual abuse are entitled to considerable support from the government, and this is not necessarily the case in any of the other participants' countries of residence. For example, in North America public health services are much more limited than

they are in New Zealand and indeed P3 was the only participant who suggested a link between attachment to posttraumatic patterns and availability of financial support. While I found this point very interesting, I would not wish to draw any conclusions that would link posttraumatic identity and financial support, and in relation to it hindering the treatment, without a more extensive investigation of this topic.

P9, another DMP from Germany, similarly to both P4 and P3, discussed clients' fears of the implications that recovery may have for them: for example, having to become independent and care for themselves.

> *People are much more afraid of change than I used to realize… this idea that ok, now, let's say I'm healthy, if I was normal, then I would have to do this and that and the other thing... they are very much afraid of all the demands that come with being fully functional… and gets so scared of that, and perhaps unable to – that they get stuck in the more pathological patterns, because they're safe, they're known... there's a saying in (local language) that says – rather a known evil than an unknown good. (P9, p. 22)*

Similarly to P3, I see here a suggestion regarding survivors of trauma whereby the clients required regular and perhaps ongoing care and therefore some degree of recovery may result with an increased independence alongside less available support. P9 was based in Germany and I contextualised a possible reference here to the social and economic conditions that are in place in their country. However, a different idea also emerged here which relates to clients' fear of change, and which I propose to be deeper than the financial and self-management implications suggested by this extract. Following on from that, I conclude that therapeutic change was indeed challenging to the clients of these participants. I propose that possibilities of change may also represent uncertainties and an unknown future, which historically may have been linked with threat and therefore may become triggers to the traumatic experience.

Analysis of the professional views expressed through the above extracts revealed the complexities that trauma effects have meant for the clients of the participants as well as possible implications for treatment. More specifically, I highlight here that the suggested attachment to the trauma and/or symptoms was considered as unpredictable and sporadic by the participants. It is important to note that in line with the individualised nature of trauma effect some clients did

not exhibit such an attachment at all. However, I feel that this theme does carry real implications for treatment in those instances where that is the case, and I therefore present it here as potentially useful to DMP clinical practice.

5.4 Engagement with the process

This theme refers to the factors suggested by the participants as supporting clients to engage with the therapeutic process. I note here that the participants did not attribute clients' engagement with the merits of their own facilitation skills but instead highlighted certain concepts which were considered as supporting engagement. Ultimately, I suggest that clients' engagement or disengagement with the process was highlighted by the participants as the clients' own choice and mostly independent of the therapist's actions or non-actions. This final group of themes in this chapter represent that factors deemed by the participants as helpful for the clients to ultimately expand their range of responses, enabled them to claim ownership over their process and increase their engagement with their therapist and the interventions they offered.

5.4.1 Clients' individuality

Most of the participants highlighted the ideographic nature of psychotherapeutic treatment and their clients' individuality. Individual client needs and preferences seemed a key factor in treatment considerations for the participants; however, at times this notion was referred to in passing rather than discussed in depth. I suggest here that this may originate from an assumption of the client-centred approach being central in DMP (to be distinguished here – however influenced by it may be – by Rogers' person-cantered framework). I posit that clients' individuality as a therapeutic consideration is embedded in DMP literature and training to such a degree that some participants may have felt that the naming of it sufficed and the common understanding eliminated the need for an in-depth discussion or explanation of the concept.

This attitude was exemplified by the following extract taken from P4, a DMP from the UK, who emphasised that they regarded each client as having their own needs to be discovered and considered during the process:

BUT, the thing is, every person does things differently, every person has their own individual way of moving. (P4, p.26)

This extract is contextualised, I propose, within DMP work methods that often utilise creative and improvisational movement explorations and are anchored in the pre-supposition that each client has their own unique mode of embodied expression. From a BP perspective, P1 (a practitioner from Canada) made a fairly succinct remark which nonetheless represented this theme of client individuality:

Well, it's so different with each person. (P1, p.7)

From this it can follow that P1 holds a similar attitude to P6 despite differences in discipline, training and country of residence. I felt that this similarity related to this specific client group, with both participants acknowledging the need to work on a case-by-case basis. I also made a link with the individual effect of trauma, where it is almost impossible to predict precisely what the posttraumatic impact would be, as well as the comorbidity of symptoms. Therefore, following the analysis of the above extract I suggest that a therapeutic attitude deemed as useful by some of the participants is one in which each client is seen as an individual case with their own needs, triggers and preferences to be discovered.

A more detailed discussion was extracted from P2, a BP from the UK in private practice, who reflected upon individuality as a factor which may impact the treatment as well as the implication it can have on the therapeutic process:

And also, it's not the same with all clients; something might work very well with one client and doesn't work at all with another client, so it's always a little bit tailored for the clients' need and the client state… so in that way it's always a trial and error kind of learning process… (P2, p.6)

This participant has linked here both therapeutic and learning processes, and I suggest that the two are indeed tied in together. Following the analysis of this extract, I now understand better the lack of an established DMP trauma-informed framework. According to this participant, the therapeutic process they facilitated with their clients was usually done individually and

creatively, and where space for adjustments was required according to the needs of the clients. In other words, I see as implied by this account that the therapeutic process needed to be re-invented, or discovered by a mutual co-creation shared by therapist and client. And from this it follows that any future trauma-informed framework of creative and embodied orientation needs to be loose enough to allow for adaptations and adjustments, to enable the individual needs of the clients to be met.

A practical example of how to account for individual clients' needs was given by P8, a DMP from Germany also in private practice, through a description of their work method:

> *I listen, I create an exercise, so it's very individualized, they can relate to, it's what they're talking about… we will go into movement, then will go at it again, we might go back, modify it or whatever, yeah, then reflect on it. (P8, p.5)*

According to this extract, the clinical practice of this participant and the interventions they discussed were very much guided by their clients and their specified and/or articulated needs. The work method expressed by P8 also links with P5's suggestions of a trial-and-error attitude, as described earlier, and where interventions are adapted or re-created in line with the individual process and needs of each client. Even though P8 described their work method differently than P5, there is the similar notion that each client may need a specific and 'in the moment' type of intervention, achieved through creative improvisation. From this I deducted the notion of an improvised and embodied approach where the client will identify their own theme for exploration and the therapist will creatively devise ways of exploring it. While it may be an approach that is already in use in DMP – for example, by this participant – following the analysis of this extract, I highlight it may be particularly useful for clinical work with survivors of trauma, and where creative and embodied methods are utilised. The above extracts suggest that those participants are conscious of clients having individual ways to progress towards recovery. Furthermore, looking at these extracts I concluded that the participants accounted for the subjective and flexible nature of DMP as support for their clients' engagement with the therapeutic process.

5.4.2 Clients' ownership of the process

The participants discussed how to enable clients to take responsibility and ownership of their own process as a factor that may contribute to the development of the therapy. The idea of ownership, I highlight here, was also important in relation to the disempowering effect trauma can have when the survivors are experiencing loss of autonomy and control during the event(s).

P7, a DMP from the UK, discussed how, in some cases, the severity of the trauma experience has had such an impact upon their clients that may have reduced their capacity for leadership and blurred their sense of autonomy.

> *It wasn't just a one off event or it wasn't just, I mean there might have been an abusive parent or there had been a death of a parent, you know - I was way too young, then this happens, then this uncle did this to me, and then this and then I went into jail and then - this is, this experience it's just layers upon layers of, of, of being… battered down. (P7, p.3)*

I include this extract here to explain why taking ownership and responsibility over their own process may have been challenging for the clients of this participant, who as result of the trauma had their perception of themselves and of the world negatively altered. Another case example was brought by P6, a DMP from the USA who was in private practice:

> *Another client of mine, umm, had parents who had no problems telling her she was an unwanted child, and they had tried to abort three or four times unsuccessfully...Yeah, so, eh, that was just the continuation of her trauma and abuse with that they reminded her all the time… among many other things. (P6, p.4)*

This extract accounts for the complexities of the attachment trauma this client experienced, and the implied impact it may have had over their sense of self. My understanding of this notion is that such level of early trauma was likely to have resulted with the client embedding low self-esteem, which in relation to the present theme may have interfered with their capacity to take ownership over the therapeutic process. Both the above examples exemplified some of the difficulties clients have had which can in turn impact their capacity to claim ownership and

leadership over their own therapeutic process. While the two examples differ in context – P7 referred to clients from low socio-economic backgrounds with substances misuse and addiction issues, while P6 speaks of a client survivor of emotional abuse and neglect – I drew a similar conclusion following analysis. I posit that in relation to the theme of ownership of the therapeutic process, in both cases the trauma occurred in childhood and likely resulted in low self-esteem to some degree and perhaps a weaker sense of self and reduced capacity for personal autonomy. I suggest that as in therapy taking responsibility over one's choices and claiming own process are marks of empowerment and are therefore challenging to engage with from a weaker position, as suggested in the above extracts.

Means of encouraging clients to take ownership of their process was suggested by P3, a DMP from New Zealand in private practice, as an important and empowering and at the same time a process that may need gradual progression. This participant described the way by which they introduce to their clients, survivors of childhood sexual abuse, the possibilities of owning the process.

> *I always try and name that and kind of, give them options of how to begin, of how to make the relationship, so that they feel like they're choosing…I'm always explaining to people that there are things that I suggest that they, umm, definitely never want to do, and some that, umm, they might want to do one day but not yet, or that they might give it a go and see how it goes and I say, you know, the more you tell me truly, you know, how a suggestion feels the more I will know what, what will work for you, and so we together discover the most, the easiest ways in, you know, to the material. (P3, p.12*)

As seen here, teaching the clients they have a choice is implemented by P3 from the onset of the therapy. This attitude corresponds with the notions discussed earlier (by P7 and P6) which highlighted the difficulties some clients faced in relation to leadership and ownership of the therapeutic process. In the present extract, P3 related their method of gently and gradually introducing the possibility of choice as well as encouraging their clients to become autonomous and lead their own process. The example given by this participant showed how using a simple mean as choice between options can support the enhancement of clients' ownership of their process. Furthermore, I also speculated that such an intervention may also serve to support the

development of the therapeutic relationship through the negotiation between therapist and client. Therefore, I highlight this seemingly simple intervention as potentially valuable for this client group and in the context of DMP practice.

5.4.3 Positive change

The interview schedule referred to the concept of positive change rather than treatment outcomes to signify a satisfactory development and/or relative resolution of the trauma experience. I chose this terminology as it is not an expression often used in the professional literature while the concept of treatment outcome is specifically defined and is often linked with quantitative research. In response to this question some of the participants, for example, referred to reduction of symptoms as a mark of positive change while others discussed an increase in self-regulation and autonomy. I also suggest here that the therapeutic process in itself aims towards positive change even though this is not always clearly stated or specifically defined as such in the literature.

P5, a DMP from Finland who is experienced with survivors of attachment trauma, identified positive change in therapy as clients gaining control over their posttraumatic symptoms, rather than the reduction or elimination of those symptoms. This participant contextualised the symptoms in their physical expressions and suggested that controlling the symptoms increased their clients' sense of control and empowerment.

> *He or she starts to notice they are able to… in a way, in a positive way, they are able to control the symptoms, like, I was able to do something, I didn't feel myself any more like a victim of the symptoms that I'm not able to do anything - so that they feel more like mastery over these symptoms and that they are able to control those things, at least a… little, or at least sometimes. (P5, p.13)*

This extract showed how through utilising DMP methods and through focusing on the embodied aspects of the trauma, an integrated positive change was attained. Another interesting point made by this participant is that through gaining some control on the physical level, some resolution of the trauma has taken place. In other words, according to this participant, the previously and negatively altered sense of self (resulting in the trauma, i.e. clients perceiving

themselves as the victim) has changed into a stronger position where the clients were empowered and had more belief in their own capacity to manage. I suggest that the use of DMP method may have contributed to the positive change reported by this participant, due to their clients having had a tacit and embodied experience of their own capacity to cope with their symptoms.

From a slightly different perspective, P2, a BP from the UK, discussed increased self-awareness in relation to psychological mechanism rather than body-based posttraumatic symptoms.

> *They can notice themselves when they start to dissociate, when something becomes a bit uncomfortable... the two of us can kind of go, is that happening? so they're more self-aware of their process, umm, so sometimes it's things like... their emotions starts to become stirred, but they can kind of, notice that and monitor that more themselves. (P2, p.7)*

This extract did, in my understanding, represent a BP perspective of the notion of embodied self-awareness as key to the development of the therapeutic process. I understood from that, following the extract from P7, that increased self-awareness in the context of survivors of trauma may have indicated a reduction of the symptom of dissociation. I highlight here that it may often be a long process comprised of small therapeutic steps to reach the level of self-awareness both these participants are referring to.

Analysis of the above extracts indicates that according to the participants, positive change seen in therapy with this client group was indeed small as opposed to current trends in trauma studies, which are looking for a significant reduction of symptoms in a relatively short space of time. Reflecting upon the above extracts, I suggest here that attempting large changes may not always be beneficial with this client group. I also found it interesting that none of the participants made claims to such an approach nor discussed methods or frameworks by which significant reduction of symptoms may be attained. On the other hand, the concept of subtle therapeutic changes did seem to be in line with relevant DMP literature and which highlighted the individual needs of clients' survivors of trauma. Further research is needed to establish the perception clients may have of the therapeutic concept of positive change achieved through DMP or indeed what successful treatment outcomes consists of.

5.5 Summary

Overall, the findings in this chapter illustrated the views and perceptions of the participants in regards to their clients and to trauma effect. The findings indicated the perceived broad range of the possible effects of trauma and resulting symptoms and that those were considered in DMP and BP practices. The participants accounted for work done with adults and children of diverse traumatic backgrounds including but not limited to childhood sexual abuse, attachment trauma, and domestic abuse as well as car accidents. Survivors of trauma were perceived to be vulnerable as a client group and this consideration was much acknowledged by the participants as an important factor which will have influenced therapeutic approaches.

Cause and effect of trauma – The first cluster of themes reflected the participants' understanding of the different characteristics of trauma and its effects as a clinical condition. The classification of possible *causes of trauma* was discussed by the participants mainly in relation to length and repetition of the experience, rather than its given circumstance. For example, a distinction was made between a single incident trauma which occurred in adulthood, such as a car accident, and a repetition of traumatic circumstances in childhood seen in attachment trauma. This finding may be useful to further current DMP knowledge and by theorising practice-based observations. The notion that trauma has an embodied aspect was agreed upon by the participants and highlighted as both an important consideration for practice as well as highly relevant to establish DMP as useful for this client group. More specifically, the participants discussed *embodiment* in relation to trauma effect, i.e. traumatic memories being trapped and held in the body, and in relation to treatment considerations. For example, means to release stored tension from the body which was perceived as caused by trauma was discussed by some, while others suggested caution due to the impact movement exploration may have on clients. It may be potentially relevant for DMP practitioners to increase awareness of the extent to which traumatic memories may be embodied and the speed by which movement exploration can bring them into the consciousness of clients.

The main effect of trauma discussed by the participants was highlighted as fear, which is not a term often referred to professional literature – either in DMP or the wider trauma-related body of work. However, analysis revealed that the participants linked different symptoms to a deep

rooted experience of fear, and suggested this emotion as highly present in the everyday experience of their clients. Finally, *dissociation* and the understanding of *triggers* seemed to be another consideration for treatment in relation to the embodiment of trauma observed with clients. For example, some of the participants highlighted dissociation from an embodied perspective and stressed the possibility of triggers being activated through creative and physical exploration. This links again with the theme of caution as I argue that the experience of dissociation and/or triggers during sessions may hinder the therapeutic process. Overall, and following the analysis of the interviews, I highlight the notion of embodiment as central to trauma-informed DMP and in particular as supportive of participants' understanding of the specific clinical needs of survivors of trauma.

Hindering factors – Following the analysis, the main factor that was identified as having the potential to hinder the therapeutic process was conceptualised here as *posttraumatic identity*. This theme was based on observations made by some of the participants in regards to unhealthy attachments they perceived with their clients and which was suggested as hindering engagements with the therapeutic process. In other words, posttraumatic identity was suggested as a hindering factor when clients were identified with the role of the victim, for example, which was then perceived as becoming integrated with the self-definition, or identity, of the client. Possible reasons for this attachment to have taken place were attributed by the participants to financial considerations as well as notions of identity. Important to mention that some cultural differences were found as potentially influencing the participants' perspective: for example, if in their country of residence, survivors of sexual abuse received financial support and subsidisation towards psychotherapeutic treatment. In which case, participants observed that getting better will have had a financial implication over the clients and in some cases may resulted with an agenda in which remaining unwell meant continued financial support. However, this was not the case with other participants and the notion of attachment to the posttraumatic identity was mentioned by other participants in the context of identity. I pose that it is a treatment consideration which is indeed relevant to clinical work with survivors of trauma, and in particular as it is but rarely mentioned in the literature. However, research is needed to establish this point further and determine its prevalence and implications for DMP.

Supporting clients' engagement with the process – This last superordinate theme in this category referred to the factors that the participants identified which contributed to the engagement of their clients with the therapeutic process. The participants conceptualised clients' survivors of trauma as having *individual needs* and this attitude is in line with DMP literature. This notion was illustrated by the participants, for example, by referring to clinical instances where transferability of interventions was not possible as each client required a tailored treatment. The participants accounted for the therapeutic process as individualised and suggested this notion guided their clinical practice with this client group from a principle level to their choice of interventions and clinical suggestions. I propose that accepting this clinical attitude as a guiding paradigm may enhance understanding of the contribution DMP can make to treatment of trauma through the use of creativity as both an approach and as an intervention. I argue that this finding serves to strengthen the need for means by which the therapeutic process can be re-created on a case-by-case basis; the work methods utilised in DMP may be relevant to this end. Therefore, as a finding I present the notion of individuality as potentially central to a future trauma-informed DMP framework.

Encouraging *clients to take ownership* over their therapeutic process was another factor which was discussed by the participants as supportive of clinical engagement. Participants highlighted this is an important therapeutic factor for clients due to traumatic histories where survivors may have been experiencing a loss of autonomy as part of the trauma, for example. More specifically and as means to facilitate ownership, participants suggested giving options (e.g. of activities in sessions) as an intervention to enable choice and decision-making, an option which some clients may not be accustomed to as a result of their traumatic history. In light of that, I highlight the notion of clients' ownership as an important theme identified in this chapter which is highly relevant to clinical work this client population and can be very useful in the context of DMP. The embodied and creative means available through the use of movement explorations, for example, may make tangible the concepts of ownership and choice to effectively support the therapeutic process. Furthermore, I argue that in light of adverse events such as sexual and physical abuse it may be an important therapeutic achievement that clients are able to re-claim ownership over their self and body, and according to this finding, I propose that an embodied therapeutic process may be a useful as means for that.

The final theme discussed in this category concerned the idea of *positive change*, i.e. the change that is produced as result of engagement with the therapeutic process and that which, for example, supported integration and a re-claiming of a sense of self. The participants discussed the means by which they noticed positive change, both embodied and behavioural, and illustrated different ways by which clients may gain control of their posttraumatic symptoms as a result of the therapeutic process. In particular relevance to DMP, the participants discussed different embodied and creative means by which positive change can be attained. For example, the use of sensations and breath exercises was highlighted as helpful to manage incidents of re-experiencing. However, further investigation is required to establish which embodied and creative interventions are useful for different posttraumatic symptoms, to enable an effective understanding of therapeutic cause and effect. I propose it may increase understanding of what creative and embodied methods are indeed effective in the context of DMP, as well as illustrate the unique value this modality have for treating survivors of trauma.

6 The Treatment

6.1 Introduction

This chapter represents the last category of findings derived from the interviews, those concerned with the therapeutic elements that were utilised by the participants for treating their clients. The analysis resulted in three super-ordinate themes, which clustered the different themes according to their perceived therapeutic affiliations (see Table 12). In other words, this chapter outlines the interventions and methods utilised to facilitate the therapeutic processes with survivors of trauma in DMP and BP, according to the clinical experiences of the participants. The first super-ordinate theme refers to the foundation of the treatment in terms of structure as well as elements that potentially contributed to a perceived contained and held therapeutic environment. The second superordinate theme, i.e., the landmarks of the therapeutic process, illustrates concepts that the participants suggested were important as part of the overall process. The third section examines the therapeutic qualities of verbal and non-verbal interventions as specifically relevant to DMP and BP. These types of interventions and their qualities were highlighted as particularly useful to clinical work with survivors of trauma, as perceived by the participants and based on their clinical practice with this client group.

Table 5 - The Treatment: Abstraction of themes

Treatment's foundations

- The therapeutic space
- The therapeutic relationship
- Trust

Therapeutic landmarks

- Assessment/aims
- Resourcing
- Trauma processing
- Ritual
- Joy

Modes of interventions

- Non-verbal
- Verbal

(Super-ordinate themes marked in bold)

6.2 Treatment's foundations

This super-ordinate theme clusters the identified core beliefs and underlying pre-conceptions of the participants that relates to the means they used to structure and contain the therapeutic process with this client group. The idea of containment as a structure and from a non-tangible perspective was suggested as important by the participants and enabling for clients to undertake therapeutic trauma processing. The following themes detail what the participants perceived as the means by which the therapeutic process is facilitated with this client group.

6.2.1 The therapeutic space

This theme referred to the conceptualisation of the non-tangible space created by the therapist, which was meant to function as a containing environment that enabled the clients to find their way towards relative recovery from trauma. This space is suggested here as something created by the therapist's focus as well as the agreement and engagement of the clients and in which the latter were able to explore and process trauma in a way that is not possible elsewhere.

P3, a DMP from New Zealand who worked in private practice, compared the therapeutic space to a training ground in which clients could have experimented and explored new ways of being.

> *Therapy is a safe place for people to try out things where they don't know what the outcome's gonna be so they kind of reclaim some of the trust in their own ability to improvise, in life, so that they can kind of be in a situation and not necessarily know how it's gonna turn out… but trust themselves to be able to respond appropriately to an unknown situation … (P3, p.6)*

This participant has differentiated the therapeutic space from everyday life, framing the former as safe and in which there is capacity to manage can be increased. The idea that was expressed in this extract may serve to define the therapeutic space as a simulated environment where clients could attempt different ways of being in relationship (with the therapist) and in the world. I highlight that this perception may have been useful to create a space in which clients were able to re-define themselves as capable individuals, a definition which may have been negatively altered as a result of the trauma. To me, this idea illustrated therapy in general as a space that was somewhat detached from everyday life and in which clients can pause and rewind lived experiences, for the sake of self-reflection and positive change. In short, and according to this P3, the therapeutic environment was a space where survivors of trauma were able to reclaim parts of themselves through the process of experimenting with different ways of being. It seemed that this was enabled due to the absence of having real-life consequences for their actions, which in turn allowed freedom of exploration and experimentation. I will also add that it is likely that the holding capacity of P3 as the therapist contributed much to creating and sufficiently containing this therapeutic space for their clients.

From a different and more trauma-focused perspective, P6, a DMP from the USA who worked in private practice, suggested that the containment within the therapy allowed clients to expose the impact that the trauma has had on them.

> *You know, a lot of people just come in and, yeah, they got themselves there and they chose to be there, but, they're going back into a state of shock when they're getting like a zombie… because you're the person holding space for their biggest darkest secret…it's (the therapy – C.G.) the place they can be the zombie… so it's an honor to hold that space, and a privilege. (P6, p.21)*

This participant illustrated the impact the therapeutic space had on their clients, and how it enabled them to reconnect with states of vulnerability and non-reaction, or to freeze. I understood this extract advocated a function of the therapeutic space in which clients were comfortable enough to embody the impact the trauma had on them. Furthermore, P6 described the therapist as the one who facilitated the therapeutic space in which the clients were able to engage with their process, including the experience of shock. I posit that this perception precedes that expressed by P3 as it relates to an earlier stage and one which is closer to the experience of the trauma and its impact. P6 referred to the therapeutic space as one in which clients can re-experience and perhaps process states of freeze and shock, while P3 framed the same concept as one in which clients can progress back to life and, to various degrees, overcome the impact of the trauma.

I feel the two different views complement each other as they refer to different stages in the therapeutic process. P6 spoke about an earlier moment when clients were in need of regressing to a passive and inactive state, perhaps for the sake of processing and accepting the experience. P3, on the other hand, referred to an active and constructive experimentation aimed at overcoming the impact of the trauma in relation to real life while re-claiming self-esteem and confidence. Therefore, I suggest that both examples illustrate the functions of the therapeutic space in relation to clinical work with survivors of trauma while articulating different stages of the therapeutic process. Both participants reflected on this topic without going into much detail, and I suggest this may have resulted from preconceptions of the agreed meaning this concept has in DMP and which rendered little need for further elaboration. I propose that

conceptualising the therapeutic space as intended to enable clients to feel conformable and secure lies at the foundation of the therapeutic process and is a condition for clients to be able to re-visit and process traumatic experiences as well as establish positive change.

6.2.2 The therapeutic relationship

The participants discussed the therapeutic relationship as a contributing factor in the establishment and continuation of the therapeutic process. The therapeutic relationship as a concept has long been established in professional literature and is embedded in DMP approaches. This was in turn reflected in the views expressed by the participants, who referred to this concept as central and fundamental in therapy with this client group.

P1, a BP from Canada who worked mainly with children and their families, emphasised the therapeutic relationship as a foundation upon which the therapy was built:

> *For me, it's all about the relationships, though it doesn't really matter what interventions we use and what our training is… it's about - can I develop this relationship with this child or this person. And so, I just feel like everything we do is, umm… it's really, the goal is about connecting. (P1, p.5)*

This participant stressed the importance of establishing a therapeutic relationship with the clients as preceding the modality and framework that is used in practice. Analysis of this extract revealed that this participant may have been undermining the weight of therapeutic skill in treating survivors of trauma due to their own lengthy and rich experience of working with this client group (20+ years). I propose that P1 may have been of such expertise in treating their clients that they may have taken for granted the technical details of their clinical practice, while focusing on what they deemed as the core of the therapeutic process. Nonetheless, centralising the therapeutic relationship as the facilitating of therapy was indeed much highlighted in DMP and BP literature as well as discussed as such by the participants.

P9, a DMP from Germany who worked with clients with substance misuse and eating disorders, related the effect that their own conscious engagement in a therapeutic relationship has had on their clients, and the importance of genuinely having been present with them.

It's also this idea of letting yourself (the therapist – C.G.) be affected, by the person, and being able to share with them in a controlled way, like if someone gets you confused, or helpless, or angry, or… eh, amused, or, moved, sad, whatever, so this, affective, self-efficacy that the patient has – to, to let them know that they are reaching you, that they're effective. (P9, p.24)

According to this participant, it was important that the clients were aware of the active and emotional participation of the therapist in the relationship, as it may help them create a renewed sense of self. The idea that was expressed here, according to the analysis, was that it was of therapeutic benefit to enable the client to know that they had impacted the therapist as it reinforced their sense of self as an individual of substance, a sense which may have been reduced as a result of the trauma. Therefore, letting the clients know that they caused an emotional impact was a way for this participant to support the therapeutic process through an active use of the relationship. I highlight the overlapping of ideas that was reflected in this extract where recovery from trauma was done through the means facilitated by the therapeutic relationship, and by which the latter was used as a tool rather than an aim. This is slightly different that the views expressed by P1, who suggested the ultimate aim was to establish the relationship as an enabler of the therapeutic process, while P9 seemed to have been utilising the relationship as a form of empathetic mirroring and with a clearly stated therapeutic aim. This may also be due to an inherent difference between BP and DMP, or it may be simply the individual clinical preferences of P1 and P9. However, despite some differences between the two practitioners, I wish to highlight the underlying understanding that much may be achieved once the therapeutic relationship is established. Furthermore, it may be the case as in the previous theme that the different views in effect complement each other in so that they represent different stages of the therapeutic process as well as different perspectives. Analysis of both extracts revealed that the therapeutic relationship was suggested by the participants as highly important and useful for treating this client group.

A different and challenging aspect of the therapeutic relationship as a clinical concept relevant for this client group was highlighted by P5, a DMP from Finland who worked with survivors of attachment trauma:

With attachment trauma it's always there, it's coming back every now and then, that the client, some part of the client feels the therapist is not trustable… even though there's already lots and lots of experiences, for the client, that the therapist has been a person that can be trusted… but, it's a… kind of contradiction inside the client, that, that… that finally the therapist will be a person that is not trustable, and we have to work with that, time and time again. (P5 p.11)

In this extract, P5 suggested that the traumatic history of the client may be reflected in issues seen in the therapeutic relationship, projected onto the therapist and acted out within the therapy. This example can imply that this participant suggested the need to consciously examine the dynamics of the relationship throughout the therapeutic process as potential indicators or manifestations of trauma material. I suggest that this relates back to the idea discussed by P9 of the practical use the therapeutic relationship may have as a working concept with this client group. However, the references made by P5 also bear some resemblance to the extract from P1, by which the relationship was perceived as serving a bigger function which can provide much therapeutic benefit. I also wish to highlight that in the latter extract, P5 potentially cautioned against a pattern they have seen with their clients and which they felt was important to name in the context of the interview. My understanding of this was that despite its appearance as challenging, the notion of trauma material expressed unconsciously through the means of the therapeutic relationship carries much potential to support the therapeutic process with this client group. From this perspective, the therapeutic relationship becomes both the aim and the objective of the treatment, which is a meeting point between the views expressed by P1, P9 and P5.

Overall, the therapeutic relationship was considered by the participants as a central element in the treatment of survivors of trauma, from different perspectives and in relation to DMP and BP. However, there remains the issue of the relationship becoming potentially reminiscent of traumatic experiences, in which case the therapist must be cautious to avoid re-enactments and unconscious entanglement with the trauma material. Therefore, I highlight this theme as indicative of a clinical need for self-awareness from the perspective of the therapist, to ensure the therapeutic relationship remains supportive of the process of recovery rather than a hindrance.

6.2.3 Trust/safety

This theme was founded on notions expressed by the participants that suggested clients needed to experience some sense of trust towards the therapist to be able to engage with the therapeutic process. I linked between this theme and the previous two – the therapeutic space and the therapeutic relationship – as I deemed all three as interconnected and having an impact on each other while creating the foundation for the therapeutic process to take place. According to analysis, this theme of trust fulfilled different functions and was related to the trust the client has with the therapist and with the process as well as with their own embodiment.

P5, a DMP from Finland who worked with attachment trauma, referred to the clients' trust in themselves and in their body as a concept that, if achieved, may further the therapeutic process:

> *And this kind of create this attitude and atmosphere that you can trust the body's wisdom, that the body knows what is best, right now, for yourself, to really let this go. (P5, p15)*

According to this, enabling the client to trust their body was done through creating the therapeutic space, so to speak. P5 referred to creating an environment in which it was possible for the client to trust their body and its wisdom; however, this participant did not give the details of how it was done in practice. Nonetheless, the notion that was expressed in this extract highlighted the body of the client as the object of the trust and I propose that it is an idea relevant to both DMP and BP. Furthermore, while no details were given as to the facilitation of the environment, this participant as a DMP will have a wide range of skills and techniques through which the clients may have been able to connect with their bodies and learn to trust them. My understanding following the analysis was that the data was sufficient to establish the relationship between the therapeutic space and the concept of embodied trust that this participant expressed. However, based on the same data, I could not determine the particulars of facilitating or encouraging the clients to trust in their bodies and its wisdom.

P4, a DMP from the UK who worked with survivors of domestic abuse, spoke of trust as connected to the therapeutic relationship, which in turn facilitated the process for their clients.

> *For me what always sticks out is when trust deepens, and that can happen ANY time, beginning, the middle or the end, whenever… for instance, when people begin to share more, about how they feel or what happened to them. So when trust deepens is when I feel trusted more… and then obviously when there's trust in the therapeutic process… so trusting and opening up to the therapeutic process. (P5, p.15)*

This participant discussed the concept of trust in the context of the therapeutic relationship and through the perspective of their own lived experience of feeling trusted by their clients. In this extract, trust was determined through the feeling of being trusted by the participant as well as in the gradual openness and capacity to relate that was seen with the clients. I suggest the trust that P4 is referring to is an embodied experience of trust and is also reciprocal, or symbiotic, and is therefore linked with the facilitation of the therapeutic relationship. This extract discusses trust as an element that happened spontaneously and as such differs from the notions expressed by P5, where trust could have been facilitated in various ways. I suggest that both the above extracts referred to a similar process from different perspectives. While the P5 referred to trust in one's own body and P4 referred to trust in another, the capacity to trust is equally emphasised by both as signified and facilitative of the therapeutic process.

This theme implied that trust was considered as a valuable part of the therapeutic process while simultaneously a result of the process and supportive of it. These different approaches to trust, in my understanding, re-enforced it as a dynamic and interpersonal concept that sets the foundation for the therapeutic process to take place. Trust was discussed from different perspectives (client-body-self/therapist-client/client-therapist), which suggested its importance in the lived experiences of the participants. The reference made by P4 linking trust to the therapeutic process, coupled with the suggestion by P5 that linked trust with the therapeutic space, both amounting to the overall thematic relationship which I highlighted here as the superordinate theme of the foundation of the treatment.

Considering the potential vulnerable state of survivors of trauma, based on the experiences of the participants seen in the above extracts, a conscious and intentional use of trust was found as supportive of clients' engagement with the therapeutic process. I posit that these findings clarify to some degree the components of therapeutic processes with this client group in terms of what

factors needs to be in place and/or aimed for. I propose that the use of trust as a therapeutic factor with this client group may have implications for trauma treatment and in the context of DMP beyond what has been explored to date.

6.3 Therapeutic landmarks

The superordinate theme of therapeutic landmarks clusters together those themes identified as the components of the therapeutic process. I conceptualised these as areas clients went through as part of their recovery rather than stages as, following the analysis, I understood the therapeutic process as cyclical and multifaceted rather than linear. The term landmarks is used to represent the importance of these concepts in the therapeutic process and yet impress that they were engaged with/visited in no particular order or timeframe. I present the landmarks as therapeutic concepts and as such they can manifest and be engaged with differently for each individual client, as well as adapted according to modality for that sake of transferability. Therefore, the order in which the landmarks are presented here is provisional and is inductive for the sake of coherent dissemination of these findings.

6.3.1 Assessment/aims

This part of the therapeutic process was referred to by some in the interviews as a preliminary or initial meeting, for the therapist to assess the clients and their needs and for the clients to evaluate the suitability of the service the therapist offers. Aim-setting was also mentioned as related to this landmark as an attempt to define some therapeutic goals that can be worked towards. Therefore, the two are presented here as one section, as I perceived that interlinks between them showed they were to take place at the same time, and as a result of each other.

P2, a BP from the UK who worked in private practice, recommended caution in relation to the details of the trauma at the initial meeting stage, as well as careful consideration of the verbal content of the assessment:

> *The first session is always kind of an assessment, a lot of history, background information… and you have to be careful with somebody who has been traumatized, you*

don't want to ask them to go into too much detail because it will be too distressing and too explosive and too overwhelming. (P2, p.4)

According to this extract, it may be advisable to refrain from asking clients to relate much about their trauma experience, as it may be distressing for them. Therefore, I deduced that this participant tended to use a soft line of questioning when assessing their clients and with much consideration and sensitivity in order not to cause clients to feel overwhelmed. This recommendation, however, relates to the initial and first meeting with a client and I suggest that assessment can also take place more than once and at different stages of the therapeutic process, when further information has become known.

From a slightly different perspective, P5 (a DMP from Finland who worked in hospitals) related their way of assessing trauma effect with their clients while encouraging them to articulate their expectations of the therapy:

And I use a lot of time in the beginning to figure out what are the issues that the client is wanting to change, or what are the issues that are most, ehhh, most harmful or bad for her. (P5, p.10)

From this it can follow that the assessment process as described by this participant, though unspecified as to its practicalities, may have taken a few sessions, rather than the initial meeting described by P2. According to analysis of this extract from P5, the assessment process was interlinked with the setting of the therapeutic aims. Furthermore, assessing survivors of trauma may not have been a straight forward thing as articulating the account of the trauma experiences was highlighted in the literature as challenging for survivors. Therefore, a lengthy process of assessment as described by this participant may have been in accordance with the specific needs of this client group. I see the notion suggested by P5 for a slow and perhaps a gradual assessment as solving to a degree the issues highlighted by P2, whereby clients became overwhelmed while accounting their trauma history in too much detail. From this perspective, I propose that taking time to assess the issues and needs of the clients could have served to have avoided distress as well as supported the development of the therapeutic relationship.

The idea of setting therapeutic goals with the clients at the onset of the therapy was mentioned by P8, a DMP from Germany who worked with survivors of sexual abuse, where direct questioning was suggested as a method to establish the aims of the therapy*:*

> *I ask them about the therapeutic contract, you know, like, what's, what's your goal, eh, for the therapy in general or even for the session of today*. *(P8, p.4)*

The therapeutic aims in this context were framed by the clients and analysis of this extract revealed it may have been an ongoing process used by the participants. I propose that by having asked the clients to set their own therapeutic aims, this participant established a frame and focus for the therapeutic process while simultaneously ensuring ownership of the process remained with their clients. It may have been the case that on a regular basis the setting of aims was casual and involved no more than a single question on the onset of the session, and yet I propose that it may have served as a regular shifting of responsibility onto the clients, which in turn could have supported empowerment. This notion bears similarities to the extract from P5, who suggested a lengthy process for setting the therapeutic aims, and in collaboration with the clients. P5 stated that it is the will of the clients which needs to be clarified first, i.e. the aims which the clients chose to engage with the therapy. Therefore, I suggest that including the clients in the setting of the therapeutic aims as a mutual process is indicated by these findings as a possible factor that could support the therapeutic process, as described by the participants.

Overall, according to the participants, assessment of trauma survivors was described as requiring particular caution and sensitivity. The possibility of clients becoming overwhelmed by recounting their traumatic histories was highlighted, as was a subsequent need to avoid too much direct and detailed questioning. Setting the therapeutic aims was discussed as a mutual effort with the clients and I propose this process may have been empowering for the latter with the potential to further a sense of ownership over the process. I also highlight this theme as an important component of the therapeutic process, which may establish focus and a sense of intention for both the participants and their clients.

6.3.2 Resourcing

Resourcing was referred to by the participants as a preparation method used to build the capacity of clients to engage with processing of trauma. It was aimed at enhancing a sense of self-agency for the clients so they can better manage potentially overwhelming material, and the participants discussed different ways to approach this therapeutic concept in clinical practice. The participants who referred to the idea of resourcing indicated the centrality of this concept as part of a therapeutic process with survivors of trauma.

P6, a DMP from the USA who worked in private practice, explained the possible meaning of this concept and differentiated between therapeutic resources and everyday ones.

> *I don't mean resourcing, like how much money she has in the bank… I'm talking about, what does she have in her daily life that makes her feel - even if it's for a fleeting moment – grounded, centered and connected, body, mind, soul and spirit. (P6, p.8)*

According to this participant, the recourse for this client was drawn from her everyday life and seemed fairly open for interpretation. Analysis of this extract revealed to me that this concept is somewhat abstract in the sense of its possibilities to manifest as anything and everything – as long as it served the purpose of grounding the client and connecting her to herself and/or the present moment. From this I follow that the nature of the resource was determined by the client mentioned by P6, as the only person of authority to determine what object or part object may fulfil the functions described by this participant.

An example for a possible resource was given by P1, a BP from Canada, who referred to the strength of a client as an object that can be made into a resource.

> *So we start to build on those resources of her courage to do this work, and the more you know those resources they are really amplified and acknowledged, and the stronger I see her becoming, and, and…and, the avoidance, the natural avoidance becomes less needed! (P1, p.19)*

In this example, courage was to become the resource the client used to manage the therapeutic process. Furthermore, this participant suggested that the resource then also became facilitative

of the process and a therapeutic factor in its own right, by fulfilling the function of empowering the client. It was difficult for me to determine from this extract whether the use of the resource identified as courage, and its possible exploration as alluded to by P1, was a primary contributor to the empowerment and reduction in avoidance described. I was inclined to deduce that in the overall therapeutic process this participant carried out with their client, therapeutic benefits were noted; however, based on this extract I propose there may have been other factors involved in addition to the identification of the resources, to have resulted in the described therapeutic progress. This clinical description differs from that of P6 where the latter clearly identified the purpose of utilising resources while the present instance from P1 attributes greater therapeutic impact to this concept. According to my understanding and analysis, I suggest it may be the case that both participants have slightly different understandings of the concept and varied methods by which it was utilised in their respective clinical work.

P5, a DMP from Finland who worked with survivors of attachment trauma, suggested that anything can become a resource as long as it signified as a positive experience for the client and was accessible at times of need in the therapeutic process and in daily life.

> *I think resources can be, eh… or there can be a variety of different recourses. For some clients there is a person in their life, which is important, like a grandmother or grandfather…somebody who has been a safe and… trusted adult in their lives… that could be one resource that we try to, try to make as strong as possible for the client to use in their daily life… like having the image of the, eh, grandmother will maybe make them feel better, also, on the bodily level, make them feel more relaxed, more calm, having some warm feeling in their body… that they can use it also in their daily life, when they have some difficult situations… but quite often the resources are somatic things, like grounding, centering, breathing, and things like that… (P5, p.5)*

This participant gave a detailed explanation as to possible forms a resource can take as well as its possible applications. According to this extract, a resource may have conceptual as well as embodied associations, both of which may have been equally effective for the clients of P5. Another important point raised in this extract was related to the use of the resources outside of the therapeutic context, where clients were able to call upon their resources in challenging

situations in their everyday lives. This point highlighted for me the function that resources may have played in the therapeutic process, one which supported me in finding the links between all of the above participants. P5 and P6 both referred to resourcing as a concept which supported grounding and by which the clients were better able to centre themselves, presumably during challenging trauma-related moments and. Another similarity between these two DMPs was their reference to the varied nature of what the resource may present for the client, which was discussed by both as potentially anything of significance to the client. On the other hand, I highlight here a similarity between P5 and P1, who both referred to the strengthening impact that resources have had for their clients, though from slightly different perspectives, while exemplifying the way in which resources contributed to the sense of self-agency and empowerment with the clients.

Overall, these participants emphasised the different functions and forms by which resources can be identified and an important point related to the flexibility and phenomenological nature of this concept. According to the above extract, resources were determined as such according to their significance to the clients, as they were to be used as anchors at challenging moments. Different perspectives were highlighted in relation to the conceptualisation of this therapeutic factor and I propose that it may have been influenced by the individual preferences and meaning-making processes of the participants, as well as their clinical experience. I propose that as a therapeutic concept, resources were discussed as having both tangible and non-tangible qualities, and it may have been that a combination of somatic and conceptual identification of this concept have best served the therapeutic needs of the particular clients in question.

6.3.3 Trauma processing

This theme referred to notions of clinical work which were aimed at accessing and resolving the traumatic experiences of the clients. The theme was discussed from different perspectives and with limited details regarding the technicalities of the interventions used. This led me to conclude it may have been an attempt to avoid generalisation from the side of the participants and that different clients may have processed their trauma in varied ways. The participants who referred to the processing of trauma in their clinical work accounted for the complexity of such

endeavour and the conditions that needed to be in place for the clients to access their past experiences in a constructive and manageable manner.

According to P3, a DMP from New Zealand who worked with survivors of sexual abuse, it was a mutual process of investigation that took place to enable the clients to have constructive access to the trauma and while distress levels were minimised as much as possible.

> *So we together discover the most, the easiest ways in, you know, to the material, umm, without being traumatizing cause that's the last thing obviously you want to do to a traumatized person, but you also want to do something novel enough, that will actually be helpful, you know… if you stay too safe nothing happens. (P3, p.13)*

This participant referred to the risk of clients being overwhelmed through exposure to their traumatic memories and highlighted the need to find alternative ways by which the clients can begin to process the trauma. In other words, there is a need for accessing or approaching the trauma in a new way for it to be useful for the client and support therapeutic processing. For example, P3 may have referred to the use of DMP and creative movement exploration which could be perceived as novel for many clients. From this perspective, DMP as a modality can offer a different approach to clients who potentially have had little experience of the unique combination of movement exploration, dance and creativity. I propose that if a useful means to enable clients to begin and access their trauma experiences was rooted in the novelty of the intervention and modality, then DMP would have been well situated to support this objective.

P5, a DMP from Finland who worked with survivors of childhood trauma, made the case that as the original trauma was experienced through the body there was a need for an embodied aspect of processing.

> *Those experiences (in therapy – C.G.) that they are able to complete something they weren't able to complete in the actual, original trauma experience… and in that way, in that level the bodily work is very important because… I have noticed it's not always enough to kind of… understand in the cognitive level… that I'm safe now, and that I'm able to do things now in a safe way… they really need to feel it on the bodily level and to*

complete those, eh… for example, defensive actions, pushing away, really feeling their own space in, in, in felt sense level. (P5, p.14)

According to this participant, there was significance in processing trauma through embodied means as it enabled the clients to have better integrated recovery and to distinguish between the traumatic past and the secure present. Furthermore, according to this extract the use of embodied means was at times required to support the processing of the trauma as cognitive method were at time insufficient. Another point that was made here referred to the means through which processing of trauma was (relatively) achieved, i.e. a resolution of the situation that was not possible during the original experience(s). The participant suggested examples that I highlight as potentially associated with physical and sexual abuse, whereby the clients used physical actions for protecting themselves in a restorative re-enactment of the experience. Following analysis of this extract I concluded that the principle of embodying restorative actions related to the original trauma was the main method of trauma processing that was suggested by this participant.

The potential usefulness of embodied therapeutic work was also advocated by P1, a BP from Canada who worked with children, as enabling processing of the trauma experiences in a way that was described as child- and client-centred.

We need to get that sensory experience of trauma but it need to be structured… so umm, right, we understand it needs to be structured, yes. And so how do we do a structured experience… and still, ah, structure but still honouring the individual need of a child, to be, to help their openness, sort of… following what the child needs, but the child needs, I believe, needs us to be guiding, in that way that we will get to the trauma. (P1, p.12)

Here the participant discussed the notion of structure as supportive and perhaps inseparable from the processing of trauma. While the extract referred primarily to the work of this participant with children, it bears resemblance to P3 in regards to the possibility that the clients will become overwhelmed and the importance of preventing this from happen. P1 was emphasising creating a structure that potentially enabled their client to connect and follow their individual needs, part of which was identified by this participant as the need to be guided. This too, in my understanding, corresponding with the extract from P3 in that it highlighted the need for a mutual process of investigation while both participants seemed to have held the space for their

clients. I also linked between the references made by P1 to the sensory, or embodied, aspect of the trauma that needed to be addressed with the similar notion made by P5. Both these practitioners, I propose, highlighted the embodied component of trauma experiences and the importance of it being accounted for and integrated in the therapeutic process.

Overall, I propose that the need to access and make sense of the trauma in a new and innovative way was discussed from different perspectives. My analysis of this theme indicated that the aim of the trauma processing was at further resolution of experiences as well as integration of the different parts of the clients that were impacted by it. However, I emphasis the notion made by the participants to engage with the trauma processing was with caution so that the clients were not overwhelmed by it. The use of embodiment as consolidating the resolution of given instances of trauma processing was also discussed and I highlight it here as contextualised in both BP and DMP, as well as being very relevant to the topic of this thesis.

6.3.4 Narrative

This therapeutic meaning of this theme was derived from the participating BPs while none of the DMPs referred to this concept. I chose to include it as I deduced it held importance in relation to the processing of traumatic experiences and in the re-construction of their story when done in such a way that supported some integration and formation of new meanings. To differentiate, I highlight that the use of the term narrative here implies the story of recovery which facilitate the therapeutic process as opposed to recounting details of the trauma event(s) – to which I refer here as the account of the trauma. Those participants who discussed this notion highlighted that the new narrative was different to the previously told accounts of the trauma both in its perception by the clients as well as the interpretations of new meanings.

According to P2, a BP based in the UK with experience with a variety of clients in private practice, for a trauma narrative to fulfil its therapeutic purpose, it needs to have activated the meaning-making processes of the clients:

> *How they perceive what happened to them and what is their beliefs system about it, what happened to them and how does it link in with their past journey and what else has happening in their lives. (P2, p.6)*

In some respects, this narration as described here may have also acted as a self-reflective mechanism through which the clients were able to position the traumatic experience in relation to other occurrences in their lives. I suggest that it may have also acted to further integration as the trauma was not explored as an isolated experience, but according to P2, it was to be connected to the overall system of the clients. In this way, I posit, the narrative was constructed through the interlinking made by the clients to other areas of their lives and increasing their awareness, possibly, of the different ways which they were impacted on by the trauma. In so doing, I propose that the account of the trauma will have changed to include the different aspects that will have been newly discovered in this process of reflecting and meaning-making, suggested by this participant.

P1, a BP from Canada with much experience working with children advocated use of non-verbal methods for constructing a narrative and asserted that the embodied aspect of the trauma cannot always be expressed cognitively:

> *We know that it's not about them being able to speak it. And what they can speak, and how they made sense of it cognitively is not… because there's a whole by story that needs to be… shared and needs to be… understood, in their body*. *(P9, p.*7)

This participant highlighted the non-verbal component needed to have been recognised and addressed to have enabled the clients' meaning making mechanism, and potentially the construction of a new narrative. According to this extract, understanding of the experience as a whole as well as recognition of the embodied impact the trauma has had on the clients was of much importance in the therapeutic process. I posit that in the attempts at understanding an experience, its meaning will have clarified and as a result, it will have also been adapted and altered. Therefore, I propose that aiming at understanding the trauma experience was likely to have resulted with some adaptation and the creation of a new narrative. This focus on understanding was shared in both extracts and I highlight that P2 and P1 expressed similar notions in regards to the story of the trauma that was carried by the clients. P1 emphasised the non-verbal aspect and the possibility that a narrative may have been expressed in an embodied and non-cognitive form, while P2 did not specify the means of expressions used by their clients. However, as P1 worked mainly with children, I contextualised the notion of non-verbal

expression made by this participants in their clinical practice and specified client group. This does not mean to say that the adult clients of P2 did not benefit from similar modes of therapeutic exploration, only that it was not explicitly discussed.

I suggest that narrative is another therapeutic concept that its importance was rooted in its impact to support the integration of the trauma experiences, originally fragmented and unassimilated. However, it was highlighted by the participants that understanding the meaning of the experience was seen as a key aim to support the therapeutic process. In short, while narrative is a potentially highly useful concept for the treatment of this client groups, the fact it was not mentioned by any of the participating DMPs was indeed a question I was left with. I present it here as a therapeutic concept with potential to be of value to a trauma-informed DMP framework.

6.3.5 Ritual

Ritual was referred to as an important part of the therapeutic process by some participants who suggested a regular use of this concept with their clients. Ritual was spoken of as utilised to begin and end sessions and this function was considered from the contextual use of this term in DMP. However, an interesting reference to ritual was also made by one participant in a broader context, as serving a deeper purpose in the therapeutic process to have enabled clients to let go of old patterns and incorporate new ones in their lives and sense of selves.

Ritual was discussed P4, a DMP from the UK who supported survivors of domestic abuse, in relation to their consideration of endings in the structure of sessions with their clients.

> *Very important also, is closure, at the end of the session. Never, never, NEVER, let them go out of the session feeling scared or unstable… really taking time for that, and making it very clear that my big wishes are for them to go out ready to face the outside world. And this is where ritual sometimes help, closing in a particular way that resonates with them, like a song or a gesture. (P4, p.12)*

This extract illustrated the function this concept served in the practice of P4 and which I understood have been aimed at supporting clients in their transition from the therapeutic space

onto everyday life. According to this participant, the ritual was engaged with in order to ensure that clients were in a relative state of self-containment before leaving the session. Interestingly, ritual here is discussed in the context of closure, while the term on its own indicates progression and transformation. Following analysis of this extract, I deducted that P4 indeed recognised the transition and used the ritual as such, while discussing the term as is conventional in DMP tradition, in relation to the closure and ending of the session. I propose that some adaptation of the ways by which ritual is conceptualised may be useful for expanding the clinical functionality of this term, one which acknowledges the transformative potential this concept may have, and with particular relevance to this client group.

A similar use of ritual was mentioned by P9, a DMP from Germany who worked at a community-based clinic, and who related a case example of clients developing their own rituals to mark the progress of their therapeutic process, as well as to signify endings:

> *Each week we would add a new movement to it and then we would do this choreography there at the beginning or the end, things like that… and also of course, if someone was leaving the group then we'd also have some kind of eh, goodbye ceremony, or ritual. (P9, p.10)*

The use of ritual as described here was embedded in the structure of the sessions and I would highlight that this concept was discussed in the context of group processes rather than individual work. It may have been the case that having a regular and anticipated engagement with a choreographic piece supported the group towards cohesion, as well as provided a tangible make making by which participants were able to embody progress and development. A point that was made here was similar to that mentioned earlier by P4 in relation to the use of ritual to frame an ending and support the participants in managing it. The difference between the two examples was that while P4 suggested this concept as regularly incorporated into the session structure, P9 proposed it was mainly used to mark the departure of group members and the ending of their process. While the two extracts portrayed a slightly different conceptualisation and utilisation of this concept, the analysis indicated both DMP participants incorporated rituals regularly in their work with their clients. Following from that, I posit that the rituals described were used

intentionally by both to frame different parts of the process and support the clients to better manage the transitions between them.

A different perspective was given by P8, a DMP in private practice with experience treating survivors of sexual abuse, who emphasised ritual as a powerful tool, used to enhance the therapeutic process.

> *And then I also like to make some rituals, to really maybe say goodbye to this victim role, or, or, saying goodbye to the past… I think it's a little bit simple in the way I say it now, but, I think we have this wonderful thing that we can make rituals, of like saying ok, so this was the past and this is over, and we bury it, we hide it, you know, whatever needs to be done, umm, to let it, let it be the past. (P16, p.9)*

According to this participant, the use of ritual was incorporated in the therapeutic process as a designated turning point and aimed at enabling to client to move away from the trauma. This participant referred to ritual in its transformative context, by which an act was chosen to symbolise and embody a transition towards an existence that was potentially less impacted by the trauma. I suggest the difference between this participant and the previous extracts lies in their respective perceptions of the meaning this concept signified. While P4 and P9 both used rituals as a regular part of the session structure, P9 used ritual in a relational context that marked a change in their group work, and which may have supported sense of value and belonging for the participating clients. On the other hand, P8 used ritual to facilitate a bigger change by which some resolution of the trauma was meant to have been achieved, and by discussing this perspective, this participant offered a notion that was suggested as highly useful to their clients.

Overall, I suggest that these extracts have illustrated different examples of ritual as a clinical tool in DMP work with survivors of trauma. Following an examination of the details of these examples, I highlight the potential importance of incorporating this concept in the therapeutic process either as a regular part of the sessions structure or as a landmark in the therapeutic process. My understanding of the relative usefulness of ritual for trauma-informed DMP lies in its deliberate and conscious use of this concept to support transition and transformation for the clients of these participants.

6.3.6 Joy

The therapeutic concept of joy was discussed as a mark and facilitating positive change as well as a somewhat complex therapeutic element. This complexity was, I propose, due to the spontaneous appearance joy made in the clinical experience of the participants who mentioned this concept. Both the DMPs who referred to this joy seemed to believe in its importance as a landmark in the therapeutic process and suggested why that was the case with their clients.

P9, a DMP from Germany who worked in a community--based setting emphasised that joy has had a transformative effect on their clients and was of great relevance to trauma-informed DMP.

> *One thing I forgot that's very important is happiness, or joy… that, when you can share a joyful moment, that has a very transformative effect…and, you know, because people always had this image of yes you have to go through all the horror, and that makes change, and yes, that's part of it… but to actually really experience joy - and that's something that umm, dance therapy is very well able to do, to have fun and to have joyful experiences, and stuff… pleasurable. (P9, p.21)*

This participant discussed joy as a concept that was less broadly acknowledged than the difficult aspects clinical work with this client group may entail: for example, the challenging nature of processing the trauma. According to this extract, the experience of joy may have been as central to the therapeutic process as other concept previously discussed in that it signified and furthered the recovery of the clients. Therefore, and in relation to the above extract, I propose that the experiencing of joy in the therapy may have been important to counterbalance the difficulties and challenges that the clients had to manage as part of the therapeutic process. Furthermore, I suggest that for clients to recognise their own capacity for happiness through the experience of a joyful moment may have been a testimony for their own progress on the path towards recovery.

A similar view was expressed by P5, a DMP from Finland who worked with survivors of attachment trauma and who offered a case example to show how they identified joy when it became an element in the therapeutic process*:*

With this one client I that still work with, now we are already in the ending phase of the therapy… she was able to find this, ehh, joyful element, of using her body again, starting to dance, doing physical exercise, having long walks in the forest, things like that, which wasn't possible for her for… 20 years or so… (P5, p.15)

In this extract, observation and self-reporting from the client were used to identify the experience of joy and the positive change that was indicated by it. According to this participant, the capacity to experience joy and with emphasis of its embodied aspect were described as a mark of positive change, potentially as a result of the therapeutic process. I suggest that this extract highlighted the link that may have existed between the manifestation of joy and the development of an integrated emotional capacity, which is specifically relevant to the clients of P5. However, and unlike P9, P5 referred to joy as a desired result of the therapeutic process rather than a clinical tool that was used to further recovery from trauma. Another point of difference between the two participants was found with the body-based descriptions of the joyful experiences witnessed by the therapist, which I found useful during the analysis to understand how joy might be identified in trauma-informed DMP processes.

I propose here that joy was identified by the participants as a multifaceted therapeutic component that was potentially both a signifier and an enhancer of positive change, and that was specifically relevant to DMPs who worked with survivors of trauma. Joy was suggested as useful, having had a positive impact on the clients and their process, and in relation to the difficulties that the latter were likely to have experienced as part of the processing of the trauma and the management of the posttraumatic symptoms. DMP in this context was suggested to having had much potential to enhance and facilitate joyful experience with the clients, as well as to have identified those through body-base observations.

6.4 Modes of Intervention

This final superordinate theme in this category is concerned with practical considerations that were discussed by the participants as supporting and encouraging the therapeutic processes of their clients. Very little was extracted from the interviews to indicate set or detailed descriptions of interventions that were perceived as useful by the participants. This present section, therefore,

refers to the mode (rather than the details) of intervention in the context of the participants' lived experiences, which relates to verbal and non-verbal methods of clinical work.

6.4.1 Non-verbal methods

The participants who referred to non-verbal forms of interventions were DMPs and gave examples of non-verbal methods that they offered to clients who were survivors of trauma, which they felt were supportive of the therapeutic process. The examples focused on the use of movement and embodied modes of exploration and seemed to have depended both on the clinical preferences of the participants well as on those of their clients.

P4, a DMP from the UK who worked with survivors of domestic abuse, explained how they use movement exploration as means for self-expression with their clients.

> *And then, if possible, there would be somewhere in the middle of the session, a very short or a little bit longer, a part where they have space for movement improvisation, around a particular scene, around a particular emotion, something they will be keen to explore, or, or, or that they want to be guided into exploration with, by me. (P4, p.4*)

According to this participant, improvisation was used to give the clients an opportunity to creatively explore their issues, by themselves or together with the therapist. This extract illustrated the different aspects that were explored in movement and the possibilities the use of non-verbal means offered to the clients of this participant. Following analysis, I highlight the wide range of areas that were indicated by P4 as possible for exploration in movement, such as emotional and re-enactment of memories. I suggest that the possibilities of non-verbal interventions may have been by far more extensive in terms of the different trauma-related issues that clients were able to explore with this participant and that the areas they have mentioned were only some examples of their overall range of work.

P9, a DMP from Germany who worked with eating disorders and substance misuse, also spoke of movement improvisation as a way to allow clients to find their own way through the therapeutic process.

We kind of do a technique where they, they go into this choreography and then, just improvise what's come next, if I really go into it and feel it then usually, umm, by itself, some kind of transformative new element of movement or whatever comes into, the scenery, and it, moves on kind of thing, and they find a solution… (P9, p. 10)

In this extract, giving the client the space to improvise has enabled them to connect to the authenticity of their own process, which may have furthered the therapeutic process and the resolution of trauma. Another point made by this participant concerned the notion of finding solutions, and I propose that this may have resulted from encouraging the creativity of the clients through their engagement with the movement improvisation. An interesting point was made here in regard to the relationship between the choreography and the improvisation that are seemingly different from each other. However, my understanding of this notion was that the choreography served as an initial structure in which the client was then able to follow up with improvisation, thus continuing their exploration in a non-verbal form. There is a strong similarity between the views of these two participants, with the exception that P9 suggested their use of choreography, while P4 spoke of the possibility of guiding their clients if they so wished. However, an examination of both extracts led me to believe that the idea of a set choreography as an exit point for improvisation does not materially differ from the guidance of the therapist, and therefore both views bore much resemblance to each other.

In short, the use of a non-verbal mode of intervening was discussed in the context of movement improvisation and I suggest it is strongly contextualised in the DMP framework. My overall impression was that the participants were aware of the potential cause and effect of their interventions upon their clients as well as the function of non-verbal methods as useful to enable individualised and tailored therapeutic processes as part of trauma-informed DMP.

6.4.2 Verbal methods

Notably, this theme was mentioned by the participant in the context of or comparison to the use of non-verbal methods in the treatment of this client group. Verbal methods were discussed as equally useful as non-verbal approaches, and verbal means of interventions were also mentioned as complimentary to embodied and creative methods that were used by the participants.

P2, a BP from the UK who worked in private practice, regarded verbal processing from a creative perspective and suggested that they offered their clients different ways to engage with verbal methods:

> *That might include talking about it – or WOULD include talking about it, but also maybe writing about it… sometimes even recording it and then listening to it, that's something I might do with some people. (P2, pp.6-7*)

According to this extract, P2 employed a variety of verbal methods and it would have seemed that a choice was given to the clients to engage with whichever felt appropriate. The notion of utilising different mediums of verbal expression was singular across the interviews and it may have related to the background and training of this participant as a BP, thereby inheriting a slightly different conceptualisation of this theme than the participating DMPs. Nonetheless, what I understood from this extract was that verbal processing was used by this participant as a mode of expression and perhaps for processing aspects of the trauma experiences. I propose that there was evident use of creativity displayed by this participant as well as consideration of the different and individual needs of their clients. I propose that such an attitude may have been very helpful to some client survivors of trauma, in terms of the choice that this participant potentially gave them to select their preferred form of verbalisation, and which may have also supported empowerment and self-autonomy.

P5, a DMP from Finland who worked with survivors of attachment trauma highlighted that verbalising the insights that emerged from embodied exploration supported the therapeutic processes of their clients.

> *Always after the body work, or movement work, we are trying to integrate other levels of experience, that, emotions, cognitions, clients' beliefs and so on… so in the end of the session we try to integrate as much as possible what has been processed, during the session…like transforming the experience in different, different forms. (P5, p.4)*

Analysis of this extract revealed to me that the verbalisation discussed here by P5 is aimed at integrating different parts of the self that were perhaps present or awakened during the exploration. Another way to look at this notion was, I propose, the verbalisation of the embodied

work supported consolidating those insights that may the creative movement improvisation may have given rise to. Either way, P5 discussed verbalisation as complimentary and supportive of the embodied and creative exploration, and following it. This presented a material difference with the extract from P2, which referred to verbal work as stand-alone without linking it to the embodied aspect of their clinical practice. I suggest that there is a potential gap between embodiment and verbalisation, and analysis of both extracts revealed the different ways by which these participants referred to this. P2 chose to highlight the verbal methods of clinical work they offered to their clients, emphasising the choice of medium to support the individual needs of their clients, which P5 described as the link they have made to bridge between embodiment and verbalisation, in order to further integration with their clients.

Overall, while there is no evidence to support the notion that trauma cannot be expressed in words, the difficulties survivors of trauma sometimes have when recounting their experience verbally was highlighted earlier in this theses. In light of that, the use of verbalisation in clinical work with this client group may have required further consideration, particularly in the context of DMP as well as BP. I suggest that these participants acknowledged the need for many survivors of trauma to have been talking about their trauma history, while simultaneously offering a variety of methods through which it may be done. I posit that attitude supported recognition of the complexity that such work entailed – both the potential gap that may have existed between verbal and non-verbal aspects of experiencing, as well as the challenge for survivors to express their stories of trauma in words.

6.5 Summary

The findings presented in this chapter relate to understandings and insights regarding the components of the therapeutic process as derived from the analysis of the interview transcripts. Three super-ordinate themes were identified, each concerning a different aspect of treating survivors of trauma, and together these serve to outline a possible frame for the therapeutic process. The participating DMP and BP practitioners illustrated the means they used in their practice with this client group which highlighted new dimensions of clinical practice and supported meeting the aims of this research.

Foundations of the treatment - This finding refers to notions I perceived as setting a foundation for the treatment of survivors of trauma and include the themes of *the therapeutic space*, the therapeutic relationship and trust. The theme of the therapeutic space was suggested by the participants to be created as a result of the attention and intention of the therapist, and in which the clients were able to freely experiment and explore their trauma-related issues, as well as new ways of being and doing. In other words, this space is a non-tangible and containing environment created by the therapist and with the aid, or agreement, of the client. More specifically, the participants highlighted that the therapeutic space enabled clients to engage with the therapeutic process, whereby conditions were available for experimentation and exploration of both trauma-related issues, as well as new ways of being. From a DMP perspective, the notion of utilising the physical space and spatial awareness may be relevant as a means to establish the environment as therapeutic, and as an intervention with this client group. The following theme was that of *the therapeutic relationship* and I propose that the two are linked and supportive of each other. The therapeutic relationship was perceived as key by the participants in regards to setting the conditions for clients to engage with the therapeutic process, and an understanding of its importance was established from the data. Some concerns were raised in regards to the relationship also becoming the scene of the trauma with the possibility of clients acting out trauma-related issues; indeed, it was suggested that this was a clinical phenomenon which was cautioned against by some of the participants. However, limited guidance was offered as to the means that may be used on such occasions, and DMP as a profession may benefit from further investigation of this notion. The final theme in this group was that of *trust* and the participants referred to this concept from different perspectives, which were mainly concerned with trust built between the clients and the participants and the clients' trust in themselves. More specifically, I highlighted the potential relevance this theme may have for trauma-informed DMP, whereby embodied interventions may be used as a means to enhance trust. Furthermore, I propose a link between the three themes as, according to analysis, the therapeutic space seemed to have had links with the establishment of the therapeutic relationship, which in turn was perceived as facilitating experiences of trust for clients. I highlight that, from a DMP perspective, all three concepts may be identifiable through tangible manifestation, for example working with distance and proximity, as a representation of levels of trust. However, further investigation would be useful to establish details of embodied and

creative means, which may support setting a foundation for therapeutic processes for trauma in the context of DMP.

Therapeutic landmarks – Following analysis, I refer to the themes in this section as landmarks of the treatment rather than stages in order to avoid a linear and phased conceptualisation of the therapeutic process. To support this notion I highlight that, according to the participants, the clients engaged with these therapeutic concepts according to their individual needs and preferences. Analysis revealed that there was no fixed order or structure in regards to the frequency or length of the engagement of clients with any of the themes that were identified as landmarks. For example, the *assessment* phase was described by the participants as preceding the therapeutic process; however, it was also suggested that assessment may be revisited and utilised to evaluate the progress achieved by the clients. Similarly, the idea of setting therapeutic aims was stressed as a mutual process constructed by both therapist and client and which was revisited and re-adjusted during the course of the treatment. The notion of *resources* as another landmark was conceptualised by the participants as metaphorical objects the identification and perceived attachment to which by the clients enhanced their utility as therapeutic tools. More specifically, identifying resources supported clients to better manage posttraumatic symptoms and trauma effect, when evoked by triggers, which overall helped develop a sense of empowerment and autonomy. From a DMP perspective, participants observed that resourcing can have embodied aspects, while nonetheless highlighting the importance of enabling clients to individually identify the form of their resources in order for this concept to serve its purpose as grounding and stabilising object.

The participants discussed the methods used for the *processing of trauma*, and different considerations were highlighted in regards to the means used for exploration and resolution of traumatic experiences. The embodied aspects of trauma and its effects were discussed in relation to the need for an individualised approach as a treatment consideration that is relevant to DMP. However, suggestions were made with regards to interventions that the participants observed were useful for processing of trauma: for example, enactment or repetition of defensive actions (e.g. punching) as completing unfulfilled fight and flight mechanism. The theme of *narrative* was primarily drawn from the participating BP practitioners and yet I highlight it here as having potential use in supporting DMP treatment for trauma. Narrative was perceived to be the

constructing of a newly altered story, which incorporated both details of the trauma and potential subsequent growth, and was useful for further processing and resolution of traumatic experiences. As such, I propose that DMP knowledge may benefit from taking this concept into further consideration. More specifically, narrative as a concept may be relevant to DMP for trauma in relation to the embodiment of traumatic memories and the potential use of non-verbal communication to express narratives in a movement form (e.g. through dance and choreography).

Ritual was referred to by the participants both as a regular aspect of the sessions, as well as holding a more special meaning as a landmark in the therapeutic process, which supported clients in acts of transformation and transition. Therefore, I positioned the notion of ritual as following the narrative, perceiving its potential to have been a form of relative conclusion that may have resulted from the construction of the new narrative. I propose that DMP is well suited to facilitate ritual as a means for resolution of trauma due to the possibilities that this modality offers for physical action and enactment. The final theme of this group was *joy*, which was only referred to by a few of the DMP practitioners and analysis revealed much scope for further investigation of this theme. While participants observed the potential that DMP has to facilitate joy as part of the therapeutic process with this client population, I highlight that the data was insufficient to identify the means by which it was done with survivors of trauma. However, the participants stressed the importance of clients to have been able to experience joy and in particularly following the challenges of trauma processing. Therefore, I chose to include joy as the last therapeutic landmark, with the view that further research is needed to illuminate the function of joy as an intervention in the context of trauma-informed DMP. I propose that this concept may be of value to a trauma-informed DMP framework, because according to the analysis, joy was perceived to indicate and support relative recovery.

Modes of Interventions – The last section in this chapter illustrated the interventions used by the participants as *non-verbal or verbal*, as well as a combination of both. The choice of either seemed to have been related to the personal clinical preferences of the participants, as well as their understanding of the needs of this client group, and in relation to individual clients. Non-verbal methods in particular were advocated and I highlight the cultural context of DMP which focuses on non-verbal communication as the foundation to this modality. Use of non-verbal

methods was also rationalised across interviews by the needs of this client group, and in relation to the impact trauma can have. More specifically, participants highlighted that the capacity to verbalise traumatic experiences was perceived as reduced as a result of the trauma, and this rationale followed by illustrating the use of non-verbal methods as helpful and supportive of the therapeutic process. Furthermore, the participants advocated that non-verbal mode of intervening enabled clients to access traumatic material without being overwhelmed, which may have been the case had they needed to verbalise their experience. However, I highlight that a different perspective was also discussed by the participants, whereby verbal processing was important as a therapeutic element to enhance the integration of the different parts of the self, alongside embodied and movement-based interventions. For example, creative writing as well as talking was suggested by the participants as means introducing a verbal component into the therapy, and proposed as accommodating the individual needs and preferences of the clients. From a DMP perspective, I suggest that the notion of combining verbal and non-verbal interventions may be useful to enhance current practice as it may be addressing the issue of verbal capacity being decreased by the trauma. For example, embodied means may be utilised to enable clients to explore trauma material in a non-verbal and therefore less threatening form, followed by the possibility of articulating in words the experience of both trauma and therapeutic processes, as an integrated intervention. In this way, combining verbal and non-verbal means may be seen as a unique contribution that DMP can make for treatment of this client population.

7 Heuristic inquiry

(Please watch the performance before reading this chapter – see Appendix A)

7.1 Introduction

This chapter is concerned with the processes and findings gained through the heuristic inquiry that was conducted as the embodied strand of investigation carried out for this thesis. This inquiry did not aim to produce new data but instead to synthesise and deepen understanding of the findings identified from the interviews. These findings were used as an exit point for a creative exploration founded on my movement practice, which attempted to replicate a DMP therapeutic process for the treatment of trauma. While new data were not produced as such, the therapeutic elements that were extracted from the interviews were explored anew and from a different (embodied and clinical) perspective, which is why I highlight this strand as an inquiry and not as continuation of the analysis. This inquiry served to cluster together previously identified findings and bring new meanings to light while gaining a more in-depth understanding of the possible components of trauma-informed DMP therapeutic processes. In this chapter I present the process of the inquiry along with its findings from a reflective perspective and in relation to relevant literature.

7.2 Background

Heuristic inquiry was used in this research to synthesise and consolidate the findings gained through an analysis of the empirical interviews. The interviews and the subsequent IPA analysis produced a detailed outline of potential factors that comprises the DMP processes with survivors of trauma. The volume of findings produced from the interviews exceeded the scope and aims of this research. I have focused in this thesis on identifying the components of the therapeutic process in the context of DMP and with the emphasis on applications and implications to trauma-informed clinical practice. However, the findings from the interviews (due to the use of IPA) revealed a much bigger picture then I could feasibly explore in this thesis. Further

clustering and synthesis were deemed necessary to elucidate and clarify those findings that were relevant to my research aims.

Incorporating a heuristic inquiry in this research was originally intended to add transparency to the chosen qualitative methodology by producing a clear and detailed description of my own meaning-making process. I propose that this is added to the overall credibility and dependability of the research (Lincoln & Guba, 1985). Heuristic inquiry is commonly followed as a stand-alone methodology utilised to engage deeply and creatively with the research topic (Moustakas, 1990; Stromsted, 2007). Now, an additional advantage I noted by conducting this inquiry was that it was used as a filter through which the findings were discerned as furthering the research aims, or not. This was a way to remain close to the original research aims in response to the volume of empirical findings. Furthermore, this inquiry allowed me to engage with a creative exploration of the findings, supported the completion of the hermeneutic circle with a DMP focus and ensured that the final results of this thesis were informed by embodied practice. I suggest that the approach to heuristic inquiry introduced here, as a means for an embodied examination of previously identified findings, is indeed innovative.

7.2.1 The multidimensionality of my role

For the sake of the inquiry I found myself having to play a triple role as the researcher, the therapist and the client. When commencing the inquiry, as the researcher I was identifying the themes named by the participants, while the therapist in me was evaluating the applicability and transferability of these themes from a clinical perspective. As the client, I used my lived experience of trauma to investigate further the meanings of the findings from an embodied perspective. From clinical and ethical perspectives, and while considering possible (mental) health and safety issues, I needed to assess my capacity to manage an exploration of trauma material. However, I felt confident enough that my mental and emotional resources would support me through this inquiry without being overwhelmed by it, as I have done much work in personal therapy and other methods to de-code my own trauma history in the past.

Bearing in mind that this heuristic inquiry carried with it an overlapping set of roles and aims, I had to integrate different aspects from each of the roles I played into a multidimensional whole

in order to engage with this inquiry. I found the process empowering and therapeutic when, for example, I as the therapist would set up the working space as the therapeutic landscape knowing that I am setting it up for my own exploration as the client. Knowing that I am taking care of myself, that I am able to contain and nourish my own process while exploring vulnerabilities, was indeed meaningful. In addition and in the background, I the researcher was systematically observing and adjusting the evaluation and direction of the work undertaken, which in my process felt like adding to its structure and purposefulness. Furthermore, knowing that my engagement with very difficult material was done for the sake of the research and to potentially enhance clinical practice enabled me to see it through at challenging moments of the investigation.

From a research perspective, this integration of roles is similar to the principle of triangulation, as I was engaged with the inquiry from three different perspectives. Having access to the perspectives and internal processes of both the roles of the therapist as well as the client has given me as the researcher a much deeper understanding than would have been gained otherwise. As the researcher, I was able to adapt methods instantaneously and based on my experience as a client or my judgment as the therapist. For example, the concept of 'joy' was not discussed by many participants and I as the researcher may have left it out as a result. However, it was my judgment as the therapist that led to include it in the therapeutic landscape (see Figure 1) as I was curious as to the meaning of this theme and its possible usefulness as part of trauma-informed DMP treatment. Another example is the theme of narrative that similarly was not mentioned by many participants, but turned out to be a substantial therapeutic theme in my process as a client and was therefore included in the map of the therapeutic landscape (see Figure 1).

7.3 Embodying theory

This inquiry was simultaneously an independent strand of research and yet another layer of interpretation applied to the findings. The notion of the hermeneutic circle informed the choice of using this inquiry as a means to further explore the therapeutic process for trauma, and from an embodied and practice-based perspective. The heuristic inquiry approach follows the principle of self-inquiry and is used to understand and explicate tacit and intuitive knowing as

its main available epistemological tool (Moustakas, 1990). Utilising creativity to engage with the therapeutic process was done in an attempt to ground my theoretical understandings of the empirical findings in embodied and tacit knowing. In other words, through this heuristic inquiry I engaged in a process where movement, dance and embodiment were both complementary and supplementary to words (Panhofer & Payne, 2011). In addition, this inquiry was also a retracing of the steps, so to speak, of the process the participants engaged with during the interviews. Therefore, in order to communicate their embodied and tacit clinical understanding of their practice they had to translate it into verbal-conceptual expression, or words, so it can be articulated and transmitted in the context of the interviews. Through the process of the inquiry I did the opposite: namely, taking the verbal content extracted from the analysis of the interviews and translating it into movement and embodied personal experience. I see this as a form of the hermeneutic circle and a means to systematically explore tacit knowledge.

As suggested above, the analysis of the interviews furthered the conceptualisation and theorising of the findings for articulation and dissemination purposes. Following the ideas of Heidegger (1978) and Gadamer (1977), it was suggested that the meaning of the phenomena can only be revealed by engagement with its original form or manifestation. In the present thesis, the phenomena in question are the processes that take place in trauma-informed DMP and their different manifestations were to be found in applied clinical practice. Therefore, in order to fully understand the investigated phenomena, I needed to re-create the therapeutic process as part of this research into its tangible and embodied form. According to Merleau Ponty (1962), the only means of engagement with phenomena and to derive their meanings must inevitably include the body. In other words and according to this, being physically present and engaged with DMP processes for the treatment of trauma is epistemologically correct and methodologically appropriate to this research. I suggest that the embodiment of theory as an investigative approach is relevant to DMP as well as to hermeneutic phenomenology and is pertinent to understand the therapeutic process for the treatment of trauma, and its components.

7.3.1 Authentic movement

Heuristic methodology and AM discipline were combined for this inquiry as both have in common the internal focus, the reliance on inwardly oriented knowledge and the emphasis on

the process (Stromsted, 2001). A similar premise is that one should remain open to the form through which knowledge is expressed and not attempt to direct the process in order for insight is to be gained (Parker-Lewis, 2007). With this in mind, I used principles drawn from AM to bring the research process back to its original starting point as anchored in a DMP framework and for maintaining methodological consistency. As I am experienced with AM both as a movement practice and as a research method, I felt familiar enough with its structure and principles to be in a good position to depict any underlying meanings related to the therapeutic process. This may not have been the case had the method used for investigation been unfamiliar, as the strains of learning a new skill may have got in the way of identifying subtle new meanings.

In terms of the AM principles that were utilised for the inquiry, these included the mover-witness duality and the mode of movement exploration used to access internal and unconscious material. The notion of having a witness that will hold the space (and the mover's experience) was chosen due to its similarity to the concept of the therapeutic relationship, already identified as an important factor in the therapeutic process for trauma. AM practice relies on the presence of at least one mover and one witness and the role of the witness is to hold space and keep time so that the mover can engage with their embodied exploration in full (Adler, 2002). The witness is committed to relate to the mover and their process/movements in a non-judgmental way while this attitude is then believed to create a trusting environment seen as essential for this practice (Adler, 2007). This attitude corresponded with the findings from the interviews that concerned the role of the therapist for treating survivors of trauma, with emphasis on acceptance and not knowing.

In AM, the role of the mover is to engage with a process of self-inquiry aiming at accessing, embodying and processing unconscious material (Chodorow, 2007). I suggest that this notion encapsulated the aims and objectives of the heuristic inquiry used here, with the exception of the unconscious material being somewhat known and intentionally investigated. The movement practice used in AM aims at letting go of the external movement so that the inner experience can be expressed through the body. This attitude holds that letting go of the forms of external movement gives freedom for internal and potentially repressed aspects of the self to emerge and be made conscious (Stromsted, 2001). This approach may be particularly relevant to survivors

of trauma in view of the mechanism of traumatic memories which render possible repression and dissociation. Indeed, allowing my body to become my guide during this inquiry supported the unfolding and shifting of experiences without my attempt to control or direct it, which resulted in the uncovering of innate knowledge. In short, the use of AM allowed me to identify and explicate tacit meanings of trauma-informed DMP practice.

Overall, the relationship between my witness and I was central throughout the process and determined its progress and quality. This relationship had some resemblance to the therapeutic relationship, even though both I and my witness perceived it as peer-based. Our connection and the presence of my witness supported my perceived sense of safety, which then enabled me to engage with trauma processing. The latter was supported through the use of AM work methods, i.e. surrendering, being moved from within and allowing hidden meanings to be expressed. This work method proved to be highly effective and I present it here to emphasise the methodological and epistemological potential this work method has to enhance DMP research.

7.4 The process of the inquiry

According to the heuristic stance, the methods used for data collection and analysis should be chosen and adjusted to match the researcher's sense-making preferences (Moustakas, 1990). While the six stages are seen to support the rigour of the heuristic process, Moustakas (1990) highlighted that they are methodological principles rather than methods. Those stages are: 1. Initial engagement, 2. Immersion, 3. Incubation. 4. Illumination, 5. Explication and 6. Creative synthesis (Moustakas, 1990), and the details of their application in this research are as follows.

7.4.1 Initial engagement

The initial engagement with the inquiry began in December 2016 through the preparation of a presentation of my thesis that was scheduled for February 2017. This presentation was to take place in the Tate Liverpool as part of Concurrent #3, a week-long festival focused on improvisation. I decided to create and embody a visual representation of my available research findings to date, which was to be presented and experienced as a workshop. At that stage, the analysis of the interviews was still underway.

Following a test run, the presentation developed into an immersive experience that was achieved through organising the space as the therapeutic landscape, utilising visual and art-based material. The main feedback received from the test run was concerned with the embodiment of the experience which was suggested as potentially overwhelming for participants. Therefore, the embodied component of the final presentation was modified and reduced to ensure participants were reasonably comfortable throughout the event. I materialised the therapeutic components by marking the floor and dividing the space into different areas that symbolised each component with corresponding signs. In addition to the signs used to title each area I added extracts from the interviews, demonstrating the meanings attached to each concept and to add audience engagement through an exhibition-like styling to the design of the space.

The presentation was conceptualised as a walking tour of the therapeutic landscape which ensured a more structured and detached approach to the experience and seemed to have worked well both conceptually and practically. A very brief embodied exploration was included, when the audience were invited to independently explore the space while noting in writing where they were drawn to and the sensations/emotions evoked in each area. In this way the experience was contained through distancing and structured guidance while the embodied aspect of the experience was acknowledged and processed through writing.

This project was in effect the beginning of the inquiry and marked the form it was to take, i.e. the conceptualisation of the process as a landscape in which one can physically move. Another impact this presentation had was in identifying my witness, a friend of mine who came to the presentation and was interested in the project. I then offered him to take the role of the witness and to further explore the therapeutic landscape for himself in exchange. He agreed and we set down some ground rules in relation to roles and responsibilities, agreeing that we will witness each other in the process. We also agreed to each take responsibility for our own process and that he will be my witness for the creative synthesis which I already conceptualised as possibly taking the form of a performance.

I deemed a performance the right form for the creative synthesis for a few reasons. First, conducting this research as part of the Department of Performing Arts was a motivation to produce findings that were in line with the environment in which I was based for the duration of

this Ph.D. Second, the workshop clarified for me that now that the therapeutic landscape materialised in the physical space, the next logical step would be to move through it as a full journey. The test run suggested it may be an ethical issue to conduct this journey as a workshop and I could not possibly have asked anyone to engage with trauma material for the sake of my research. Therefore I decided to engage with the process myself and undertake the journey through the therapeutic landscape from beginning to end, with the added notion it may be an opportunity for me to enhance the findings of this thesis and my own knowledge. Thirdly, a performance will include that the audience is present in the space and, therefore, will inevitable and physically engage with the process. Fischer-Lichte (2016) suggested that performance is a result of the bodily co-creation of performers and audience, both being active participants in the experience, which, therefore, makes it unique in time and space. This notion corresponded with the AM perception of the connection between mover and witness, where the movement experience is directly related to the engagement of both (Stromsted, 2007). Therefore, it may be argued that every person in the audience contributed and was indeed an active participant in the performance as it took place. Finally, I felt that a performance would disseminate the findings as anchored in DMP practice as well as enable the audience to have their own embodied experience of a therapeutic process for the treatment of trauma.

Considering the above, I perceived that having the creative synthesis taking the form of a performance would meet the research aims in a way that would be methodologically, epistemologically and clinically effective and appropriate to DMP practice.

7.4.2 Immersion

The immersion stage began at the end of March 2017 and was carried out until June 2017, when the creative synthesis was presented. I followed Moustakas' (1990) suggestion to open up to the process and engaged with potential insights whenever they were presented. Active and embodied investigation of the topic took place twice a week on average in two to three hours' slots. My external witness was present in at least one session per week. The studio we worked in was arranged as the therapeutic landscape with signs naming different therapeutic concepts dividing the room into different areas (see Figure 1). My witness and I would begin with a verbal check-in followed by a warm up, which usually included recorded music for no set length

of time. We would then move onto movement/dance exploration with or without music, as felt appropriate and agreed by both of us.

In the first few sessions we moved together with each of us engaging with their own process simultaneously and later coming together to share and close as each other's moving witnesses (Frieder, 2009). After the first four or five sessions we shifted into a more focused structure where following the warm up we would engage with AM, taking turns of being mover and witness and following the AM structure, experimenting with and without a verbal exchange (Adler, 2002). After we both moved and witnessed each other we would close the session by discussing new meanings emerging in relation to specific trauma processing or past insights while reflecting of the process as a whole. I video recorded my own movement explorations but not those of my witness as he wished to not have his experience recorded (for examples of exploration see Appendices I). My individual sessions followed a similar structure with the replacement of the lived presence of another with a video camera, and the verbal discussion was supplement with a written reflection (see Appendix J).

7.4.3 Incubation

Incubation tended to occur between sessions and when a need to withdraw from active exploration was apparent (through physical/emotional exhaustion and reluctance to engage) it was recognised as times to allow incubation to take its course. Due to the clarity of the heuristic framework it was possible to accept the need for occasional rest and withdrawal as a valuable stage in the overall meaning-making process (Moustakas, 1990). The incubation periods were not long and a few days at most were taken for internal processing, which corresponded with the usual time gap between sessions - as these took place approximately twice a week.

Exploring the concept of incubation helped me to distinguish between myself as the researcher, who took time off from direct engagement to incubate understanding, and myself as the client, who took time off to avoid the difficulties presented by trauma processing. While the latter was anticipated it was nevertheless a challenge to contain my trauma-processing journey in a way that would not interfere with the research process but further it. Indeed, managing the trauma material was very taxing at times. However, the use of AM and trusting my impulses (to

withdraw, for example) helped to keep the balance between the different roles adopted during the inquiry process. Following an impulse to move or be still, to directly engage with the inquiry or to withdraw from it for a while was useful in helping me to recognise my boundaries and maintain my inner resources during the process.

7.4.4 Illumination

Illumination occurred at different stages of the inquiry and tended to present itself in the form of insights (Moustakas, 1990). Those insights would have had an embodied expression as part of movement exploration or occurred during reflective writing or as thoughts surfacing while I was engaged with other activities. When an illumination occurred I noted it down in writing, often in the form of questions or reflections (see Appendix J). However, when illumination occurred during movement it seemed to simultaneously arise from the movement as well as guiding it and as a result the subsequent insights were seen as tacit and nonverbal. I suggest that these embodied illuminations stemmed from the AM practice and originated from unconscious processing expressed through physical movement (Stormsted, 2007).

Also, certain music pieces were identified as having a particular emotional significance as triggers or as provoking/encapsulating past experiences. These tunes were noted down with a brief description of the experience as well as further elucidation of their symbolic meaning. For example, a certain song evoked a sense of constriction and entrapment, resulting in an improvised choreography which I titled as ‘dancing in a box’. While I was engaged with the movement experience of dancing inside a small constraint I had insights into some of the impact trauma has in that it greatly limits the survivor’s emotional and action ranges. This led me further to reflect upon my own history and notice the areas where I felt my capacity to act were limited following trauma experiences. This realisation evoked a strong sense of sadness, which was very much embodied (see Appendix I).

In that instance I understood this aspect of trauma effect from an embodied and personal perspective while the impact of this experience was almost overpowering. This meaning-making process was very different from the cognitive interpretation utilised during the analysis of the interviews. This level of understanding could not have been gained if I had not explored it in an

embodied and a practical way and the result of which translated into the creative synthesis/immersive performance.

7.4.5 Explication

Explication manifested in the form of written trauma narratives, movement improvisation and the refinement of the therapeutic landscape, all contributed to my deepening understanding of trauma-informed DMP. The written narratives reflected the culmination of the therapeutic process and even though these took a written-verbal form they were linked in with movement exploration and choreographic scores. The first explicated narrative, for example, resulted from a particularly powerful session where I found myself using my hands and doing movements that pressed me down onto the floor. I was hiding my face in my hands and then I began to rub by face with my hand in a repetitive pattern and much force. The overall experience was distressing, and I could not say exactly why that was the case when discussing it with my witness afterwards. The following day I felt quite disoriented and emotionally dazed and still I could still not say why that was the case. At some point during the day I stood in my room and brought back the embodied experience to mind and then began to retrace the movements I was doing the previous day in the session. I began to rub my face with my hand and suddenly I was flooded with a vivid and long forgotten childhood memory of having been sexually harassed. It was so vivid, as if it had only just happened, and I was shocked to realise I had forgotten about this incident.

Even though this memory was accompanied by a mixture of distressing emotions I was surprised to notice I was not entirely overwhelmed. I found myself writing the whole incident down in an impulsive way, which resulted in a coherent narrative of the experience. An interesting thing was that the narrative also included my interpretation of the event as well as my responses to it and not just the details of the experience. This additional meaning-making I considered as semi-spontaneous processing, which in my understanding distinguished the written piece as a trauma narrative rather than an account of traumatic history (see Appendix K).

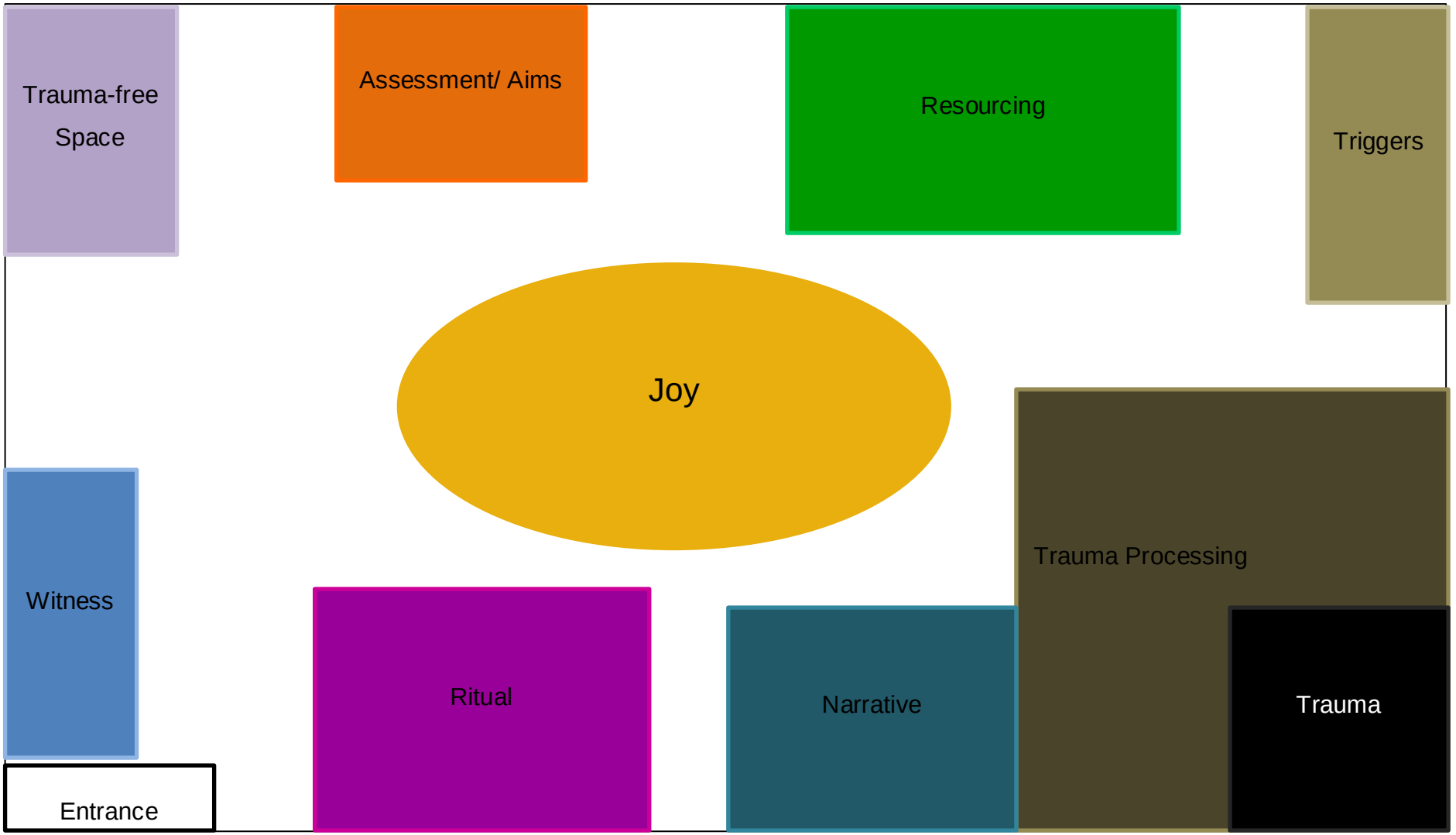
This explication experience served a double purpose in the inquiry as it represented a meaningful piece of trauma processing and simultaneously explicated the therapeutic use of

embodied work as well as narrative. The explication was tied in with the preceding AM process of movement exploration and revealed meanings concerning the therapeutic process for trauma. Similarly, other experiences of embodied explication brought together personal, creative and research processes that held meaning on both individual and conceptual levels. In relation to the hermeneutic circle, I suggest that the explication is the moment in the investigation where the different parts come together momentarily to allow engagement with understanding of the whole. This then provided a new perspective of the phenomenon, which could have then been followed by a further examination of the parts in an ever-deepening cycle of understanding (Gadamer, 1977; Smith, Flowers & Larkin, 2009).

7.4.6 Creative synthesis

This final stage of the inquiry concerned the clustering and synthesising of the data in a form that was meant to represent the nature of the findings as well as reflecting the process of inquiry (Moustakas, 1990). In this thesis the creative synthesis took the form of the immersive performance, constructed with the aim to enable the audience to have an embodied experience of DMP processes for the treatment of trauma. It was deemed appropriate to the embodied meanings that resulted out of the inquiry and tied in with DMP practice and for their effective dissemination. Incidents of explication – verbal and embodied were clustered and synthesised to create a meta-narrative of my journey through the therapeutic landscape. The aim of performing this journey was to represent my intellectual, embodied and tacit understandings of what trauma-informed DMP practice may entail. I wanted to present the findings in movement form to demonstrate DMP for trauma treatment as it may be seen in a clinical setting.

Figure 1 - The map of the therapeutic landscape


Trauma-free Space
Assessment/ Aims
Resourcing
Triggers
Joy
Witness
Ritual
Narrative
Trauma Processing
Trauma
Entrance

7.5 The performance

The performance was funded by EHU and costs were divided between the graduate school bursary fund and the Department of Performing Arts research support fund.

The performance was in effect a meta-narrative that represented the results of the parallel processes of research inquiry and therapeutic trauma processing, and was in line with the methods used for exploration. The journey of the trauma processing was used to illustrate what was discovered about trauma-informed DMP and its implications. As part of constructing the creative synthesis, written reflections that accompanied moments of explication were selected, edited and resulted with the trauma narratives used in the performance (see Appendix K). A professional storyteller was recruited to record the narratives. I chose to employ another to record my trauma narratives as I wanted to be free to move and fully immerse myself in the embodiment of my process. I felt that live speaking would restrict my movements, while having the narratives spoken as a voice-over during the performance could serve to represent a thought-process which may bring the audience into my internal world and support experiential immersion. It was also an artistic choice to maintain a high standard of the material disseminated, and stemming from acknowledging my own limited capacity as a spoken-word artist.

Finally, considering my personal process as the client I did not feel capable of speaking the trauma narrative and be able to embody them in the same time. This links with the literature that suggested the difficulties survivors experience in verbally recounting the details of traumatic events, and the distress that often accompanies articulation of traumatic history (Johnson, Lahad & Gray, 2009; van der Kolk, 2015). I felt I was capable of listening to my own narratives being spoken by another without being overwhelmed, as it created some distance which enhanced my self-management capacity as a client. This choice freed me as the researcher-performer to embody my responses to those narratives so that I could adequately disseminate my findings, and represent the impact of the trauma as well as illustrate the therapeutic process of recovery in DMP.

I came to view this performance as my own personal ritual that would allow me to resolve the trauma in parts and as the findings from the interviews suggested. As such I was experimenting with the concept of ritual and much consideration was given to this aspect so I could

successfully complete the therapeutic journey. The costume was in effect an expression of the ritual I engaged with and was specifically designed for that purpose. Careful planning ensured that I could remove layers of clothing after each narrative to symbolise the notion of self-exposure. The act of taking the costume off gradually represented the process of trusting others while becoming more exposed and vulnerable – personal traits that I struggle with due to the impact trauma has had on me. The colours were intentionally chosen, the outer layers were white and symbolised a whole and healthy outer appearance – and yet these were slightly see-through so that the darker under-clothes could be seen to represent the damage caused by the trauma. The hand-marks on the under-dress symbolised sexual abuse and the experience of feeling tainted and marked. These were aesthetically arranged in a 'fashionable' way and in the back the marks formed a pattern that resembled a pair of wings, which symbolised the concept of posttraumatic growth. The final set of underclothes was entirely black and in the performance these represented coming to terms and accepting the trauma as a part of me. At this point of the performance I will have 'come out' to the world as a survivor of trauma who owned my history and accepted it, and as such I have little to hide.

With the aid of my witness the narratives, recorded music and ritual were arranged into a patterned sequence that was to represent the journey from initiating therapy onto a relative resolution of trauma and empowerment. The sections of the performance corresponded with the components of the process and symbolised journeying through the different areas of the therapeutic landscape (see Table 6)

Table 6 - Illustration of findings as represented in the performance

Performance (see Appendix A)	**The map** (see Diagram A)
Initial engagement/transitions	Trauma-free space/aims
Movement improvisation/recorded music/AM	Resources/trauma processing/joy
Recorded narrative	Trauma/trauma processing/narrative
Custom/undressing	Trauma/ritual
Audience/witness	Witness

7.6 Reflective discussion

This section is my reflective discussion of the meanings that were revealed through the process of this inquiry. As I took upon myself the role of the client, the therapist as well as that of the researcher I have had the rare opportunity to reflect upon this process from a triangulated perspective. However, it was not always easy to differentiate and categorise insights as belonging to this perspective or the other due to the natural merging/integration of these different aspects in the whole of me. As a result, I will focus here on my own process of moving through the therapeutic landscape and the implications it had on me and contextualising it whenever I can. I do this to illustrate the practical experience of this inquiry, the understandings I gained and their clinical and theoretical implications for DMP in the context of treatment of trauma. To do so, I discuss the different areas of the therapeutic landscape in an order similar to that in which I journeyed through it in the performance.

7.6.1 Witnessing

The concept of witnessing was central to this inquiry and I highlight here four different aspects that manifested through the process of investigation and dissemination. These forms of witnessing were 1) the named outer witness who accompanied me throughout the process, 2) the inner witness - the non-judgmental part of me that I developed as part of my internal process, 3) the audience at the performance, and 4) any subsequent viewers who will see with the recording of the performance.

The presence of my outer witness was fulfilling in part the role of the therapist and enabled me (as the client) to engage with trauma material, which I may not have been able to do alone. In practice, when engaging in movement or AM the fact that there was someone there that was willing to hold space for me supported my capacity to go deeper inside myself and to engage and express difficult material. I was unravelling my experience of feeling tainted and flawed and yet he stayed with me and did not judge me for it. This was a crucial point for me as I realised how much negative judgment I directed towards myself and how frightened I was to be seen doing exactly that.

My inner witness was developed and became more resilient to the trauma material, I feel, as a result of my being seen by my external witness. Adler (2002) suggested that the inner witness is

that part of us that holds account of everything that takes place during the movement exploration and is devoid of judgment. This internal part does not direct or interfere with the movement, emotional response or imagery but rather accompanies it, representing a compassionate and accepting self-gaze (Holifield, 2007). The process of learning to trust my witness and his capacity to manage my traumatic history was also my process to trust myself, which resulted with a gradual release of my long-standing defences. This part of myself I was learning to trust was, I posit, my inner witness. It may be important to name that, as an experienced AM practitioner, I was making intentional use in my already developed inner witness. Nonetheless, as a consequence of this process I was beginning to see more and more of my trauma experiences. This correlation between self-trust, self-witnessing and what is named as desensitisation - an enhanced capacity to manage exposure to my trauma material - was indeed a finding that the researcher in me was particularly excited about. What I have seen was that by ensuring certain conditions were in place, i.e. the presence of my outer witness and an intention to develop my inner witness, a healing process was taking place.

The third aspect of witnessing in this inquiry concerned the audience who were present in the performance, and who witnessed it. This aspect is a curious one as it combines elements from both fields of psychotherapy and performance, and is positioned in the liminal space where investigation and dissemination overlaps. I emphasise here the notion suggested by Fischer-Lichte (2016) of embodied co-presence, or co-creation that asserts a performance, is the result of the active engagement of performers and audience alike. According to this, audience will become active participants in the creation of a performance by their very presence and engaged attention. In relation to this performance, I feel it was even more so the case due to the personal nature of the material preformed as well as the pre-existing mover-witness connection. This relationship was established over months of mutual and intimate exploration and acted as a backdrop to the performance and potentially influence the audience unintentionally. I never planned on positioning the audience in the witness role. On the contrary, I was concerned much judgment and criticism will be triggered during the performance which is why I needed to have one constant and trusted witness to hold my space and process. Nevertheless, I feel that by and large the audience did fulfil the role of witnesses. This was perhaps possible due to the fact I authentically undertaken a therapeutic process and enabled myself to engage with my own trauma material, and by introducing genuine non-judgmental witnessing into the space.

Therefore, the audience inevitably and unconsciously (or perhaps consciously for some) was effected and which resulted with authentic engagement with the performance.

An example of perceiving the audience as witnesses could be found, for example, in my act of gradual undressing during the performance that symbolised my increased capacity to be seen as vulnerable and exposed. The act of undressing also represented my enhanced ability to manage the trauma material without having to have layers of protection to separate me from these trauma experiences. However, an unexpected consequence of this literal and metaphorical removal of items resulted with a sense of trust and empowerment. I feel this was only made possible through the process I underwent with the audience and the mutual sense of trust that developed during the performance and as a result of me acting as the mover with all that this role means (authenticity, trust, exposure, etc.), positioning them as the witnesses.

The fourth form of witnessing I consider here concerned the experience of viewers seeing the recording of the performance. In my opinion, due to all of the conditions that were present in the performance and the fact that it was a highly intimate piece of work, viewers seeing the video may potentially be affected emotionally and cognitively, as well as have an embodied response to it. However, in a few ways this last aspect differed from the previous three. First, witnessing the recording will have no impact on this inquiry in a sense that the recording is a finalised product and cannot be influenced or altered. Furthermore, the performance represented a liminal space where the findings were disseminated but also consolidated and refined. Therefore, the embodied presence of all who were physically in the room – my witness, the audience and I as the mover – are all factors in the final shaping of the findings of the heuristic inquiry. The recording of the performance, on the other hand, is again unaltered in this context which makes the witnessing of it a slightly different experience as there is no embodied relationship between the witness of the recording and the mover. Therefore, while it is certainly possible for a viewer to adopt the witness role, there is no mover to receive the witnessing and be affected by it. While I may still receive responses and feedback from prospective viewers who witness the recording, this does not denote a witness-mover connection as we did not share the embodied moving experience. In other words, with witnessing the recording performance there is not the embodied co-presence in the physical space. Therefore, it becomes the witness' exclusive (and nonetheless embodied) experience of witnessing a recording of a performance. And that, I argue, is not the same as witnessing the mover move whilst being present in the room with

them. It may still be regarded as witnessing, providing the witness assumes the same state of mind of non-judgment etc., and yet it is a form of witnessing that exceeds the bounds of the concept as I explored it in this thesis. Therefore, the question of witnessing in regards to the recording of the performance touches upon different and extended areas that, I feel, concern phenomenology of different forms of media, and thus goes beyond the scope of this thesis. I propose that further research is needed to explore the phenomenon of viewing recorded live performances and in the context of witnessing to better understand this experience and its possible meanings.

Overall, the act of trusting my outer witness to see me non-judgmentally in the embodied expressions of my vulnerability enabled me to trust my own capacity to manage the memories of my trauma experiences. These in turn enabled new meanings to emerge which enabled my inner witness to be made present and signified some integration of the experiences into a more cohesive narrative. Once this was achieved, I was able to open up my story and present it in public, whereby a large group of strangers became my witnesses and with whom I shared personal and intimate historical narratives. It was through this process that the findings for this thesis were consolidated, the heuristic inquiry was completed and the hermeneutic circle closed.

7.6.2 Trauma-free space

The idea of having a designated trauma-free space evolved when after the first month or so of inquiry sessions I realised that my witness and I tended to drift away at the end of the sessions from the topic of what we explored to other areas. I felt uncomfortable about it at first as if we were not fully committed to the investigation, but I wanted to allow the flow of the dynamic between us to evolve organically. Therefore, it became a regular part of our closing discussion where we would shift our focus to daily life as a way of concluding the sessions. Indeed, there very well may have been a tension between engaging with difficult trauma material and pursuing lighter and less challenging topics during the inquiry. This would have been on my part when the researcher in me felt a need to stay focused on the topic of this thesis. However, it was becoming clear that exploring trauma for two hours was just too much and our change of focus at the end of the session may also have been a way to prepare for re-engaging with the outside world. This tendency was seen later in the warm-up phase, where we would deliberately choose ‘happy’ music. I suggest here that having a trauma-free space was likely to have been equally beneficial to the process we undertook as was the direct engagement with the trauma material. I

feel that my witness's pull towards the trauma-free space in the sessions was helpful to our relationship and useful in diffusing any stress that was caused due to the trauma work.

7.6.3 Assessments/aims

Due to the nature of this inquiry and the fact it was not therapy I did not state therapeutic aims when I initially began the embodied exploration of the therapeutic process. The explicit aims related more to the research and the heuristic inquiry when the overall intention was to explore and consolidate knowledge through embodied and creative means. Therefore, I can only comment belatedly on what may have been some therapeutic aims, from observation of the outcomes and from the impact this process had on me. In other words, due to the nature of heuristic inquiry as a research method I could not have set therapeutic aims without interfering with the course of the investigation.

I included the concept of assessment/aims in the map as I derived it from the analysis of the interviews and I acknowledge its importance to clinical practice. However, in this investigation I gained little embodied meaning in relation to either clinical assessment or aims. I propose that the framing of this inquiry was one where the assessment and setting of therapeutic aims could not have been effectively investigated, precisely because it requires the pre-defined therapy structure, and a therapeutic relationship. As I was researcher, therapist and client, I could not create the therapeutic relationship with myself as such, and my witness was by no means acting as a therapist. Furthermore, I engaged with this inquiry with my aims clearly focused upon achieving knowledge and not therapeutic recovery from trauma, which already distinguished the process as research and not therapy. In other words, out of all the areas in the therapeutic landscape that I present here, this is the one that needs further investigation the most for its meanings and potential value to trauma-informed DMP to emerge. I propose that there may be some aspects of clinical practice that cannot be fully explored outside their original context. However, I chose to include this theme here as I feel, as the researcher, therapist and client that this theme holds meaning that may benefit from further research.

7.6.4 Resources

This concept stemmed from the idea that in order to manage the therapeutic process for trauma, clients need to have some resources that could support them during the process when distressed or overwhelmed. The findings from the interviews indicated that personal qualities were used by

the participants. For example, inner strength and/or courage that may have helped the client to manage their trauma experience were turned into resources. However, I found that even though I recognised some trauma-related and personal attributes similar to the above that could have qualified as resources, these were overridden by the negative traumatic associations. For example, the feeling of guilt and shame was very dominant to the extent that I could not find anything in the trauma experience I could feel proud of, or strengthened by. Therefore, I needed to explore other avenues to identify my resources. I tried to adopt some exercise I found in BP and DMP literature: for example, anchoring in physical sensations or creating a resource-integrating movement, positive association/memory and visualisation. These exercises, however, did not work for me and it may be my lack of training or interpretation – I read these in books rather than being guided by a skilled practitioner. Either way, I could not ground myself in my body as a resource while experiencing it as the source from which trauma memories were flooding into my consciousness. Moreover, attempting to use physical grounding techniques and not succeeding increased my posttraumatic sense of failure and disconnection from my body.

The resources I finally identified as helpful were, to my surprise, related to my everyday life and presented as objects of positive association, such as certain relationships and/or individuals with whom I was connected. For example, my mother and my grandmother's strength became my resource; knowing that they survived their own trauma experiences enabled me to ground myself in difficult moments. This insight and resource also became part of the last trauma narrative used in the performance (see Appendix A). As my current conclusion to the exploration of this theme I discovered the personal nature and form through which resources may be presented. I reflected that my engagement with trauma-informed DMP did not necessitate the use of the body as a tangible resource or an anchor. Rather, it is the use of the movement exploration and the overall process I engaged which elucidated what finally became my resources.

7.6.5 Narrative

Narrative as a therapeutic factor emerged spontaneously during the heuristic inquiry and I use the term here to represent newly-integrated meanings of the trauma experience that resulted from the process. I wish to distinguish the narrative as a therapeutic concept from an account of the trauma experience or history, as I experienced both in the inquiry. The two differ, insomuch

as the latter is embedded in the past and is a transmission of the trauma experience, dominated by the subsequent negative impact it have had. Narrative on the other hand contained the trauma experience as well as possibilities for (relative) resolution and positive change. Both my witness and I found that telling, or recounting, our trauma stories was incredibly difficult and distressing and was not very helpful in the long term. On the contrary, when we attempted in the beginning of the process to share our trauma stories it felt artificial and we both experienced disconnection to various degrees in the attempt to share verbally. We later agreed that it was so difficult to relate the experiences in words, that disconnection was a way to manage the feeling of being overwhelmed. After that we agreed to only share in words for as long as we have a sense of body connectivity, i.e. attune to our embodied self-sensing during the verbal sharing, stop whenever anything felt overwhelming and maintain self-care at all times.

During the inquiry, my first narrative emerged, or presented itself, as a result of the movement exploration. (This movement experience was described earlier in this chapter - I found myself rubbing my face and cheek with my hands which was later understood as a memory of childhood sexual harassment.) I argue that before the memory clarified into a cognitively accessible account of the event, the narrative was already forming in an embodied way. As a consequence, the following day when the memory re-surfaced and I had written it down I found that with the details of the experience, new elements were added to the story. I use the word ‘added’ as I did not contrive or think of those beforehand but found them being written through me, in a similar way to when I was being moved from within when doing AM. These emerging interpretations and understandings of the trauma were concerned with self-care and self-protection in a dialogue between the adult and the child in me (see Appendix K). I suggest that this dialogue and accompanied new conceptualisation of that trauma resulted from the embodied work where, through the inward intention enabled by the use of AM, my unconsciousness began to creatively integrate parts of the experience. Therefore, when the memory resurfaced, it already carried traces of the process that was taking place deep inside me as part of the therapeutic process. In other words, by the time the suppressed knowledge of the experience reached my consciousness it was already undergoing the transformation process, from an account of a traumatic event into a trauma narrative.

Following this, I argue that the role embodiment had in creating the trauma narratives was inseparable from the verbal component of it, and both were equally needed for me to find some

resolution of the traumatic experiences. My understanding of the relationship between verbal and embodied expressions was reflected in the performance where both the verbal and non-verbal aspects of the trauma-narrative co-existed and complemented each other. I wish to add that there is also the possibility to develop a trauma narrative that would be entirely non-verbal, embodied or indeed musical and/or visual. However, these findings indicated that marrying verbal and non-verbal means enabled different aspects of the trauma to be modified and some resolution was gained for me through the construction of the narrative.

7.6.6 Ritual

I feel I truly gained an embodied understanding of the theme of ritual only towards the end of the inquiry. However, similar to the notion of narrative, I believe that the purpose, form and meaning of this theme were incubating in my subconscious for some time before becoming illuminated and explicit. This is result of, I believe, a spontaneous creation of liminal space (Turner, 1977), which enabled my engagement with the concept of ritual and elevated it into an experience which bears some resemblance to a rite of passage (van Gennep, 1960). In many respects ritual was a continuation of the different narratives functioning to finalise a relative resolution of trauma, which concluded the narrative. In other words, the ritual was the clustering of the different narratives into the meta-narrative, which was finally performed. In this way, the ritual was both the form and the substance: the liminal space that facilitated my transformation, despite the fact I did not know it at the time. Indeed, when I began to plan the performance it seemed an appropriate means for dissemination of the process and findings of the inquiry. The fact it became part of the inquiry, of the therapeutic process and the final moment of illumination and explication was only revealed to me during the final rehearsals when the different components of the performance were assembled. Perhaps it was the creative and artistic process of curating the performance – materialising and giving meanings to the costume, the playlist, the recorded narratives and the movement score – that made me recognise the significance of what the performance was becoming.

Throughout the inquiry, I as the researcher included this theme without having had a clear sense of its meanings in the context of trauma-informed DMP. I had some ideas drawn from the literature that concerned release and resolution of the past and parting from old preconceptions: for example, letting go of the victim role. However, I still did not quite understand how it is to

take place in practice to ensure that the transformation was indeed to happen. Therefore, I left this theme aside and decided to allow it to incubate while trusting some meaning will be illuminated and I will gain some understanding of the value of ritual in the context of my research. As the inquiry progressed and the date of the performance drew near, I came to realise that the performance itself was becoming a ritual on its own, through my focus upon it and effort that it required as an undertaking. The realisation, or illumination, was in response to recognising my own reluctance to be seen as exposed and vulnerable, and that this difficulty was in fact a posttraumatic effect. Following this understanding, I felt that the process of recovery had to incorporate and address these issues. However, due to the time restrictions and the approaching date of the performance, I was not at liberty to delve into further movement-based exploration and needed a different solution. As the performance touched upon and challenged exactly these areas I struggled with, I decided to make the journey through the therapeutic process a ritual of exposure and vulnerability. This was approximately two weeks before I was due to present and so I had just enough time to prepare conceptually, emotionally, mentally and physically. In this preparation stage that was in many respects a liminal space I finally began to understand what the meaning of ritual was for me, and how I embodied it in the context of my own process.

The performance became the ritual itself; however, it was inseparable and impossible to achieve without the preparation stage that was founded on the previous illumination, which in turn had arisen from the narratives. The ritual indeed framed the process and performance into the synthesised meta-narrative which, similarly to the hermeneutic process, encapsulated the different components and gathered them into a whole that was larger than the sum of the parts.

7.6.7 Joy

I included joy on the map of the therapeutic landscape based on the findings from the interviews that suggested it to be a component of the process. I included this theme in the inquiry as I was curious, seeing it was a not a topic often referred to in DMP literature in relation to trauma. In practice, I found this area of the process highly challenging and I struggled to connect with it or even to be in the part of the room affiliated with this concept for most of the inquiry. Managing the traumatic material meant inherent exposure to a full spectrum of negative and difficult feelings, and I found my lack of ability to engage with joy overwhelming. The fact was that by

having that theme physically present in the room (in the form of a sign) also meant there was an expectation that I should be able to experience joy and yet I felt incapable of doing so. This brought up much shame and self-blame as well as highlighting an area by which I was much affected by traumatic experiences I have had – my capacity to feel joy was limited to non-existent in the presence of the traumatic material. Also, I may have unconsciously avoided feeling joy as it meant I then also avoided the full extent of the negative feelings that were evoked through the trauma processing. In other words, the lack of capacity to feel joy may have signified some emotional dissociation and this experience was also apparent in my external life for a large part of the inquiry (approximately two months).

The ability to feel joy was possible again only when I identified my resources and framed the performance as a ritual, while working towards self-acceptance through the final stage of the rehearsals. Also, similarly to my exploration of the theme of ritual, I had to let go of joy before I was able to access it. In other words, I had to accept my not-knowing in relation to this theme as a researcher, as the therapist and as the client. Perhaps it was the process of letting go that enabled joy to be present again, but perhaps it is also cannot be artificially facilitated. Either way, I could not have brought myself to a place of joy during this inquiry; rather, it was the joy that found me as it was one day there, moving through me. This highlighted to me the potential importance of this concept in trauma-informed DMP, and how in my process it was both an aim and a signifier of recovery.

7.7 Summary

I utilised the heuristic inquiry to discern the themes that contributed to fulfil the research aims and illustrated their meanings through an embodied and practice-based inquiry. The structure of the inquiry was organised in such a way as to resemble DMP clinical work to ensure the knowledge gained was embodied and practice-based and to bring the hermeneutic circle to a close. Principles from AM were used as methods and the witness-mover connection was to substitute and reference the therapeutic relationship. This investigation culminated with an immersive performance that related the journey I took through the therapeutic landscape. Presenting the findings in the form of a performance was done to effectively disseminate the meanings of the therapeutic process and its components, as I understand them and in relation to clinical practice. In the course of the investigation and in line with both the therapeutic process

and heuristic inquiry, the performance also functioned as a ritual of healing and recovery. This signified the lived quality of the research in that the creative synthesis encapsulated all six stages of the heuristic inquiry, had meaning in the context of the therapeutic process and acted as the dissemination of the findings.

In the process of the inquiry I became aware of the difference between the way I understood the therapeutic concepts in theory and the way by which I understood them in practice. This insight presented more questions than answers in regard to the problem of translating embodied and clinical knowledge into verbal and academic expression. This is a core issue in DMP as a movement-based practice that much of the embodied knowledge is challenging to theorise and I suggest that in the translation of knowledge from tacit to verbal, some meaning will be lost. However, the results of this inquiry suggest some solution to the way in which DMP theory and practice may complement each other in future research and in possible ways for its dissemination. The use of creative approach and AM methods were particularly useful to bring together verbal and tacit understandings and to mediate between the two in the communication of the research findings, and in enhancing DMP and trauma-informed knowledge.

8 Concluding Discussion

8.1 Introduction

In this thesis I set out to gain an in-depth understanding of the therapeutic process and its components in the context of trauma-informed DMP. This concluding chapter provides an overview of the research I conducted followed by a summary and discussion of the main findings and their potential implications and value to DMP knowledge. While the knowledge gained from the analysis of the interviews was indeed rich and contributory to an understanding of what consist of trauma-informed therapeutic process, the findings exceeded what was required to answer the research questions. The research aims specifically targeted the therapeutic process and therefore in this final chapter I mostly discuss what I deemed as relevant to answering the questions which initiated this thesis. As the gap in the DMP literature relating to treatment of trauma is concerned with the lack of a framework, the contribution to knowledge I highlight in this thesis is what may serve to establish a foundation for such a working tool. Therefore, in this chapter I have extracted those findings that seemed to support the construction of a trauma-informed, DMP framework. Finally, I suggest the ways by which further research on the topic may be developed beyond the scope of this thesis.

8.2 Summary of the research strands

This research involved two main research strands. The first was an empirical research that involved semi-structured interviews with DMPs and BP who are experienced in treating survivors of trauma. The second was a creative and practice-based heuristic inquiry, which was founded on the findings from the interviews as the primary source of data.

8.2.1 Semi-structured interviews

The first strand of research involved semi-structured interviews with DMP and BP practitioners, experienced with treating survivors of trauma. Analysis of the interviews resulted in rich and detailed accounts of the factors that constitute therapeutic processes for trauma treatment that utilise creative and embodied methods. The themes from this strand were organised into three

categories and disseminated in this thesis as three individual chapters (Chapters 4, 5 and 6). These categories represented understandings gained regarding The Client, The Therapist and The Treatment, and served to illustrate the therapy as a system. Furthermore, these findings elucidated the factors that comprise of therapeutic processes utilised in trauma-informed DMP, and BP. Indeed, through the use of IPA and the hermeneutic circle I attempted to map these categories with the end result of a detailed profile of each. This section reiterates the main findings of this strand and illustrates their relative relevance to the topic of this thesis.

8.2.2 Heuristic inquiry

The heuristic inquiry was used to discern and identify the concepts that were relevant to answering the research aims out of the large volume of findings, and then examine and elucidate them through creative and embodied practice. I suggest that the resulting creative synthesis served to ground the theoretical conceptualisation of the findings in an embodied and lived understanding, and with a clear distinction between the two. I highlight here this distinction to be the difference that exists between thinking and doing, between discussing a plan and executing it, between seeing a photograph of a room and physically being present in the space.

I arranged the findings in a map as a creative solution to include the findings identified in this research that would not be conceptualised as an area and yet I felt were contributory to a trauma-informed DMP process. For example, the form of a map accounts for the individuality of clients and their process, as it is inherent that while the process can contain fixed stations each client may visit different areas and in varied order. Therefore, the form of a map was better in reflecting this finding than, for example, a treatment protocol that would have suggested a fixed order in which therapeutic concepts are engaged with. Another example is the idea that clients can engage with the different areas at their own pace and as often as needed, which is again being addressed through the conceptualisation of the process as a map. In short, I present the therapeutic landscape here as a succinct and synthesised representation of the overall findings in this thesis and one which illustrates the parts and the whole of a trauma-informed and DMP-oriented therapeutic process.

8.3 Summary of the main findings

8.3.1 The therapist

This category represented a provisional and professional profile of the participants as trauma-informed practitioners. According to the present findings, notions of resilience and the need to self-manage were particularly prominent considerations suggested by the participants in relation to their practice with this client group. The impact that the trauma material can have on the therapist was recognised by the participants, who highlighted the need to ensure their continued wellbeing and professional capacity. Baum (2009) posited that the impact embodied trauma material can have on the therapist and that in the context of DMP this notion has not been sufficiently investigated to date. Forester (2007) highlighted that practicing DMP with survivors of trauma requires caution and awareness due to the potential risk for the therapist to experience symptoms presented by clients and as result of mechanisms involving empathy and embodiment. A possible solution to this risk was suggested in the form of establishing a DMP framework that will support therapists when working with survivors of trauma (Forester 2007).

The finding of resilience was perceived by the participants as essential to the clinical work with this client group even though as an attribute it was seen as non-tangible and not much detail was given as to the means by which it can be developed, apart from length of experience. When resilience is discussed in the literature it is often in relation to clients' survivors of trauma and van der Kolk (2015) referred to resilience as one of the central attributes that enable people to survive traumatic events. The current findings clearly show that the notion that the therapist needs to be resilient to effectively practice with this client group has been much more dominant in the interviews than the resilience of the client. I suggest resilience here as a key factor for DMP clinical work with this client group as it testifies to the strength and endurance of the therapist to withstand difficult clinical and traumatic material, thus validates them as a 'good enough practitioner'. As a clinical attribute, the presence or absence of resilience may have much impact over the therapeutic process. The question remains how can resilience be built and enhanced in the context of DMP and in relation to embodiment, and further investigation is required to elucidate the implications of these findings.

The notion of the therapist's not-knowing is identified here as part of an attitude required for clinical creative-embodied work with survivors. However, the discussion of the notion in the DMP literature, when it is indeed being referred to, is marked by ambiguity. Meekums (2007) spoke of the notion of not-knowing as a personal attitude meaning to enable internal material to be expressed through the body, a notion linked with authentic movement practice. Allegranti (2013) and Edwards (2015) on the other hand discussed knowing and not-knowing from a political perspective and challenged long-standing assumptions of the therapist-client relationship and consequent power relations. The ways by which the participants discussed this topic can be seen as combining these two perspectives. I suggest that the attitude of not-knowing as discussed by the participants was making space for both the known as well as unexpected to emerge during sessions, and further quality within the therapeutic relationship. Considering the disempowerment that often accompanied traumatic events, I believe this attitude to be relevant to the DMP treatment of survivors. I also suggest that by occupying a not-knowing position, the therapist may then make space for the clients own sense of knowing, which in turn may enhance the therapeutic process. This attitude towards clinical work is seen as central for the treatment of trauma, though is currently under-researched in the context of the trauma-informed DMP.

Overall, professional hazards that are related to trauma were not often discussed in the creative arts therapies (Johnson & Lubin, 2015): for example, the phenomenon of vicarious traumatisation (Pearlman & Saakvitne, 1995) has rarely been addressed. With regards to these notions, I highlight in the findings from the interviews the concepts of resilience of not-knowing, to suggest that professional hazards were indeed recognised and addressed in clinical practice by the participants. These findings indicated that practice may be more advanced than the available literature, looking at the lived experience of the participants. These findings highlighted a gap between the literature and current practice which I deem as an important one to fill due to the potential impact exposure to traumatic clinical material can have on novice practitioners.

8.3.2 The client

One of the key features that these findings highlighted was that perceiving the client as an individual is an important consideration for treating survivors of trauma.

According to the participants and following analysis, I suggest that the assessment phase and the development of the relationship in particular should be approached anew with every new client. According to van der Kolk (2003, 2007, 2015) the manifestations of trauma effect can greatly differ in clients and the idea of co-morbidity of symptoms is unpredictable, and complicates treatment consideration. Following analysis I suggest that the participating therapists were aware of this individuality in which trauma may manifest and therefore they tended to discuss adaptable work methods, which corresponded with conceptualisation found in the literature. DMP literature also suggested that while trauma has a similar neurological impact on survivors, interrelationships between symptoms differ (Pierce, 2014), and where one may suffer from nightmares and social anxiety, another may develop an eating disorder and misuse of substances (van der Kolk, 2015). The findings relating to this category indicated that these notions are being considered by the participating DMPs and BPs in relation to trauma-focused clinical practice. However, while BP literature does make use of case studies, generalisation can often be found, and I posit it is perhaps due to a tendency of presenting clinical practice in the form of suggested frameworks and exercises (Rothschild 2000; Ogden, Minton & Pain 2006; Levine 2010). In DMP literature the tendency is quite the reverse, perhaps due to ample case studies and caution against overgeneralisation (Gray, 2001; MacDonald, 2006; Helmich, 2009). However, I suggest here that an understanding regarding the individuality of clients, their needs and their processes may be a compromise that can be used to begin establishing a trauma-informed framework that will also be adaptable and transferable. Overall, in line with DMP literature (Gray, 2001; McDonald, 2006), I suggest that with each client there needs to be a process of mutual discovery in order to identify their therapeutic needs and preferences.

8.3.3 The treatment

This section of the findings is concerned with the therapeutic means used in practice to treat clients' survivors of trauma. In this section I gathered the themes that felt closest to fulfilling the research aims and as such these were transferred onto the heuristic inquiry for a further practical and embodied investigation.

The main and overall principle that was identified in this category and which, in some respects underpins many of the other findings, highlighted the ideas of creativity as fundamental to the trauma-informed DMP. According to the analysis of the interviews,, creativity is one of the unique contributions of the DMP to trauma work. The use of creativity in creative arts therapies

treatment for this client group was suggested as a highly useful means to engage with and process trauma experiences (Johnson, Lahad & Gray, 2009). Indeed, Lahad et al. (2010) regarded the use of creativity as supplementary to direct exposure (i.e. the explicit and repetitive accounting of the traumatic history) through what they termed as imaginal exposure to trauma material, which was seen to further trauma processing. The findings from this thesis indicated that this notion was common among the participants as was the agreement that encouraging creativity supported the process of the clients.

However, I propose that not enough research was conducted into the context of DMP to examine the functions creativity fulfilled in the therapeutic process for survivors of trauma. DMP Current literature highlighted the use of creativity for trauma but references tend to be in the form of generic statements rather than practice-based (Dieterich-Hartwell, 2017; van Wesrthenen *et al*, 2017). Furthermore, references to creativity do not seem to highlight the multifaceted ways in which this concept can specifically support recovery from trauma through embodied methods. I propose that creativity can be used, as suggested by Johnson et al. (2009) and Lahad et al. (2010), as a less threatening way to access trauma experiences. In addition and according to the findings from the interviews, creativity can be used as means to enable clients to re-create their sense of self. Overall, through these findings I wish highlight the possible uses that the concept of 'creativity' specifically has for the trauma-informed DMP framework once it has been established as a fundamental component of the therapeutic process

8.4 Discussion and contribution to knowledge

8.4.1 Trauma, embodiment and resourcing

In support of the notion that the use of embodiment can be an effective means of bridging possible gaps between verbal and non-verbal aspects of traumatic experiences and client's ability to articulate these, these findings lend support to the suggestion made by Johnson et al. (2009) regarding the value of embodied methods for both supplementing and complementing verbal processing of trauma. This notion is also similar to observations made Penhofer and Payne (2011) with regards to DMP as helping clients to verbally articulate their embodied experiences. In the current research both the practitioner interviews and the heuristic enquiry highlighted the combination of verbal and non-verbal/embodied methods as both relevant and appropriate for treatment of this client group. The meta-narrative presented in the performance,

in this way, included both spoken-verbal and embodied non-verbal expressions of the trauma experiences as well as the therapeutic process. This was because the process of undertaking this research transformed profoundly my understanding of the interconnectedness of verbal and non-verbal modalities in the context of trauma treatment. I argue that while these two aspects of the process could have been utilised separately, the therapeutic impact would, to my mind, not be as powerful. More specifically, the embodied work provided a non-verbal mode of expression that was powerful and effective, while the verbal narratives consolidated the emergent understandings and meanings. Therefore, adding verbal components to the embodied and creative exploration may have enhanced the overall therapeutic impact as well as supporting emotional and cognitive integration.

These findings further illustrate the need to consider carefully the embodiment of trauma when applying creative and movement-based approaches to treatment. This need for caution was highlighted during the interviews by the participants who suggested that these methods may easily trigger traumatic memories. This finding contrasts with the DMP literature which has a tendency to affirm the value of DMP and does not always account fully for the extent to which embodied methods can affect clients. For example, DMP work frequently emphasises the usefulness embodied therapeutic processes can have to access, express and process traumatic material (Lavy, 2005; McDonald, 2006; Baum, 2009; Dieterich-Hartwell, 2017). Similarly, BP literature emphasises the use of embodiment and body work as positive and effective methods to access and release traumatic memories trapped in the body (Levine, 2010; Ogden & Fisher, 2014). However, current findings in relation to therapists' views regarding the perceived value of embodiment in DMP brought to the fore parallel concerns regarding the risk of inadvertently triggering an immediate and overwhelming impact on clients.

Data derived from interviews with therapists further highlighted that the use of embodied resourcing was regarded as a helpful means of managing the DMP therapeutic processes with survivors of trauma. Identifying supportive elements from everyday life as well as the use of sensations, for example, were regarded by participants in this research as the strengths of the approach. In the heuristic inquiry, however, these methods were found to be only mildly helpful because I found there to be a substantial gap between the theoretical idea of resourcing and its embodiment in practice. It may therefore be possible to suggest that the concept of resourcing may be more complex than often portrayed in the literature. To illustrate, in relation to BP Rothschild (2000) argues that anchoring in the body can be used as a resource to enable clients

to distinguish the past from the present through concentrating on physical sensations (e.g., during re-experiencing). This is conceptualised as a process that is achieved by increasing awareness of physical sensations (Rothschild, 2000). DMP, in a similar vein, utilises similar concepts, often referred to as 'grounding', and which are meant to enable the clients to connect with their bodies through different methods (de Tord & Bräuninger, 2015). By highlighting a more complex interplay between the idea of resourcing and its practical application the current findings therefore contribute to a more in-depth understanding regarding the complexities of this therapeutic notion. I propose that this is an example of the distance that lies between theory and practice in DMP due to the embodied component and which renders further investigation.

Findings from the heuristic inquiry revealed that a small amount of movement exploration was sufficient to evoke my trauma-related memories, sensations and feelings that were suppressed or dormant for years. Therefore, and despite having some inclination of the possible impact movement work can have following the findings from the interviews, I was still struck by the depth and speed by which traumatic memories came into my awareness. These findings were in line with current trauma and neurology literature which poses that traumatic memories are stored in the body (van der Kolk, 2015). An exception can be found with Meekums (1999) as one of the few who reported that DMP work in particular was challenging to clients, who at times were overwhelmed by the embodied aspect of the therapeutic process. This factor was presented alongside the perceived value that creative and embodied methods had in accessing traumatic memories as well as processing those (Meekums, 2000). It was through the process of the heuristic inquiry that I came to understand the degree to which traumatic memories can be embodied, and the swiftness by which movement work can bring those into consciousness. I argue that alongside the suggested benefits that DMP for trauma and the use of embodiment may have, there is an underlying challenge that can be more widely considered. Therefore, it may be useful to highlight, that alongside the benefits of embodied methods in DMP for this client group there is also need of caution to allow clients to access the trauma in a paced manner.

In short, these findings reveal a more complex perspective of the use of non-verbal and embodied methods to access and process trauma. I wish to highlight the need to consider some challenges of using DMP for treatment of trauma and which are under-acknowledged in current literature. While the findings in this thesis attest the usefulness of embodiment as a therapeutic component, its effectiveness also suggests further consideration may be useful to establish its function in DMP for trauma.

8.4.2 The therapeutic relationship, trust and witnessing

Current findings highlight the extent to which the therapeutic relationship is multifaceted and functions as what may be described as a container for the therapeutic process. The participants in this study viewed the therapeutic relationship both as a training ground for everyday life and as one in which the trauma may be constructively re-visited and corrected. In other words, respondents regarded the therapeutic relationship as a central component of their work with survivors of trauma, for example in cases where a lack of trust was suggested as a posttraumatic effect. In this way, current findings support the view that trust-building in interpersonal relationships is a key to facilitate clinical work with clients who are survivors of trauma (Fosha, 2003). In her work, Fosha (2003) for example, highlights that with this client population, therapeutic processes may be a long-term endeavour because the capacity to trust and engage in interpersonal relationships may be reduced. Ogden et al (2006), relatedly, suggest that, over time, the therapeutic relationship serves to increase capacity for affect-regulation for clients who experienced attachment trauma. This notion is echoed in the present findings in which the therapeutic relationship was seen as an interpersonal container in which clients may develop new coping mechanisms and tools to better manage difficult emotions. In this way the relationship between the therapist and client becomes the centre of the therapeutic process as well as its enabler and I highlight the combination of acceptance and boundaries as a factor that may encourage trust, increased capacity for affect-regulation and support the clients of the participants to engage with the therapeutic process.

The therapist interviews in the current study highlight further the extent to which the therapist may come to be seen by the client as what may be described as a role model. In this way, interviewees stressed the value of clients being able to relate positively to another through building trust in the therapist, thereby lessening some of the impacts caused by the trauma. In the current study this was perceived to be of particular relevance to clinical work with survivors of childhood trauma. In a similar way, Siegal (2003) as well as Fosha (2013) suggest that a new attachment to the therapist may be a valuable therapeutic means that can facilitates overcoming original and more insecure attachments. By identifying that it is the conscious engagement of the therapist with trust-building mechanism that may encourage clients to experiment with new and potentially healthier relationships, the current thesis adds weight to this assertion. As indicated by the participants, accepting that the therapist is indeed trustworthy becomes part of the therapeutic process, and which in turn is likely support recovery. From this perspective, my

findings illustrate the complex considerations therapists need to be aware of when treating clients who are survivors of trauma to recover trust as an inherent posttraumatic effect. In view of these findings I highlight that while this notion is well-discussed in the wider trauma literature, there are specific DMP features that needs to be further accounted for: for example, embodied manifestations of trust and creative means to the building of it as part of the therapeutic relationship.

Moreover, analysis of the interview transcripts revealed further that in some cases the therapeutic relationship itself may become the scene of the trauma. For example, participants suggested that clients may be triggered by the therapist as part of the therapeutic process. Interviewees stressed the need for awareness of this possibility when working with survivors of trauma in order to avoid potential unconscious enactment of traumatic dynamics. Maintaining the wellbeing of clients in this way may present particular challenges to novice therapists who have little experience with this client group and who can benefit from further and more detailed guidance regarding explicate the complexities of DMP for trauma. Current findings therefore contribute to work emphasising the importance of having an established trauma-informed DMP framework in place (Baum, 2009), which may enhance training and further development of knowledge.

Reflecting on this further and in relation to the findings derived the heuristic inquiry, the notion of witnessing as a manifestation of the therapeutic relationship that is specifically relevant to DMP became apparent. More specifically, the heuristic inquiry highlighted both the therapeutic importance of having a relationship with and also a sense of increased self-connection that was a consequence of my relationship with my external witness. The concept of the inner witness, in a related way, was suggested by Adler (2002; 2007) as a way of thinking about awareness that observers experience from within (i.e., from the "I" position and through a curious and compassionate perspective). This notion does not impact on the need for an external witness (i.e., typically the therapist), but stresses the importance of both. Indeed, the presence of the external witness during the inquiry enhanced my connection with the part that represented my inner witness. In DMP context, the outer witness is likely to be the therapist and their non-judgmental attitude it believed to be supportive of the development of the inner witness (Adler, 2002; Stromsted, 2009). For example, during the heuristic inquiry I managed the trauma-focused explorations better when my outer witness was present in the room. Therefore, I suggest that my inner witness was initially more available at the presence of my outer witness. In other words, I

was better able to access and manage the trauma material and subsequent processing while I felt being seen and held by another.

In my experiences, different aspects of witnessing were both inseparable from, and facilitative of, the process of the inquiry and, as a finding, proved to be valuable to my exploration of the therapeutic process. For example, I overcame my fear of being seen in my vulnerability and therefore experienced greater freedom, which is reflected in the last musically accompanied dance of the performance, which symbolised empowerment. According to Herman (1994) traumatic experiences can involve an extreme and unwanted surrender and this is often interpreted afterwards by the survivors as failure and weakness, resulting with feelings of guilt, shame and blame. Dokter (2010) further highlights that clients may struggle with being witnessed in their embodied exploration due to the level of exposure this can create, despite it also being a potentially powerful and helpful experience. I suggest that the findings presented here are in line with such theorising, and they can be used as a starting point for further research into the role of witnessing in DMP treatment of trauma. I propose that a controlled process of surrender within the container of a therapeutic relationship may be a supportive means for clients to re-build a sense of trust and overcome some of the effects of the trauma.

Considering the link between witnessing and the therapeutic relationship further, during the inquiry and through the regular use of AM I slowly developed my inner witness' capacity to be present rather than dissociated while exploring trauma material. In my experience, this would not have been possible without the presence and support of my external witness. As I related earlier, one of the trauma narratives that was used in the performance was founded on an incident I had forgotten for many years (see Appendix K). That event was indeed overwhelming and, at the time of its occurrence, I had no psychological or bodily tools to manage it. As a consequence it was never fully processed and instead repressed and forgotten as means of coping. In the literature the phenomena of delayed memories (partial or even full amnesia) are attributed to people's coping mechanism when faced with overwhelming events (van der Kolk, 2015; Van Westrhenen *et al*, 2017). The findings from the heuristic inquiry suggested that reinstalling the inner witness into the trauma experiences was an important therapeutic element that supported establishment of meaning and recovery. However, to my mind that would not have been possible without the presence and support of my outer witness. I propose that my experience of having been contained and held by another served as what may be described as a

replica of the therapeutic relationship, through which I was able to derive new meanings out of that trauma experience.

Overall, a number of conclusions with regards to the therapeutic relationship and witnessing can be drawn through consideration of the present findings. First, both concepts appear to be inextricably linked and highly relevant to DMP clinical practice for the treatment of trauma. Second, the perceived loss of trust as a result of the trauma highlights the importance of the engaging in a trusting and therapeutic relationship which can function as a container in which paced processing of trauma can take place. I emphasise here the notion of witnessing as multifaceted and facilitating of the therapeutic relationship and process. Third, I propose that this concept may be particularly helpful for trauma-informed DMP and, based on the findings from the thesis, witnessing may indeed be a powerful contributory element in the facilitation of recovery with much potential value for this client population.

8.4.3 Narrative and trauma processing

Narrative as a therapeutic concept was identified in this thesis as having the potential to play a central role in trauma-informed DMP. Findings from the heuristic inquiry indicated that the narratives that were used in the performance were not only accounts of traumatic history, but also reflected processing of trauma. In other words, the act of constructing the narratives during the inquiry was found to be embedded in a newly gained meaning-making capacity that was not available beforehand, which resulted in further processing and integration of trauma. The notion that the meaning-making capacity can be decreased by traumatic events is supported by neurological theories and was highlighted earlier in this thesis. Van der Kolk (2015) observed that brain scans done during survivors' experiencing of flashbacks revealed reduced activity in the subjects' left brain hemisphere, the side of the brain that is linked with cognitive, verbal and mental processes. This neurological notion indicates that trauma reduces the capacity for verbal articulation and perhaps cognitive processing as well. It was suggested that for as long as the person's psyche rejects the trauma, knowledge of it may be delayed and/or incomplete (van der Kolk & McFarlane, 2007; Ogden, Minton & Pain, 2006). Findings from the interviews highlighted the difficulties that some clients may have had to articulate their traumatic experiences, which led participants to advocate the value of embodied and non-verbal clinical work. However, based on the present findings I argue that an intentional use of narrative as a therapeutic concept may be of great benefit supporting treatment of this client group. While

verbal expression of the trauma was indeed challenging during the heuristic inquiry I perceived the construction and expression of the narratives as spontaneous and I argue that it was a progression that resulted from the movement exploration. Therefore, I propose that the narrative both reflected and consolidated the trauma processing I engaged with as well as supporting integration of embodied and cognitive aspects of understanding.

From this it may follow that the findings in this thesis elucidated a work method that combined non-verbal and verbal processing and where cognitive understanding followed the embodied insights. I highlight that the newly constructed narratives originated from tacit forms of knowledge and linked together embodied traumatic memories with the therapeutic process I undertook. The traumatic memory phenomena, which contains reminders of the event as sensory and emotional fragments, was suggested to potentially disrupt verbal articulation and pose a major challenge to clinical treatment of this condition (Herman, 1994; van der Kolk, 2015). As highlighted earlier, in DMP there is an emphasis on non-verbal means of expression which can supplement the need to verbally recount the details of past traumatic experiences (Meekums, 1999; MacDonald, 2006; Pierce, 2014). Furthermore, the creative arts therapies were advocated as offering an alternative to talking therapies, and that psychotherapeutic arts methods may be in some cases just as helpful to clients as verbally-oriented treatment (Johnson, 2009). In addition, dramatherapy literature suggests that verbally recounting the details of traumatic events on its own does not necessarily support the therapeutic process (Jones, 2010). However, this approach is in contrast to evidence-based treatments for trauma which advocate the telling of the trauma experience in a detailed and repetitive manner, as it is suggested to achieve desensitisation as a means to enhance recovery (Foa *et al*., 2009). If it is indeed the case that traumatic memories are stored at least in part in a non-verbal form, then I suggest that the use of non-cognitive methods is appropriate to access and process the trauma impression stored in an embodied form. Following the present findings from both interviews and inquiry it seems that referring to the details of the trauma event on their own was not supportive of the overall process. In contrast, applying embodied and creative methods to enable exploration was found as helpful and furthered transformation. Furthermore, an unexpected result of the work method which I followed during the inquiry was the construction of verbal narratives that integrated traumatic memories with the story of recovery as well as produced newly found meaning as a mark of positive change.

In short, with the current findings I offer a conceptualisation of the idea of narrative as facilitative of the therapeutic process and through which positive evolution and transformation of the trauma may be detected. These notions are in line with previous notions which argued that DMP is a potentially helpful method to address the issues posed by the unusual nature of traumatic memories due to the use of non-verbal and embodied means (Meekums, 2000; Baum, 2009; Pierce, 2014). However, the use of verbally constructed narratives in the context of DMP for trauma is currently under-researched. A particular benefit of using narrative as a therapeutic concept is that it is continuously evolving as a result of engaging with new experiences (Jirek, 2017) and therefore may be a useful means for evaluating clinical practice. This idea supports the present findings, and I argue that the engagement with the narratives during the inquiry enabled access to the traumatic memories while simultaneously highlighted the process of recovery, integration and positive change. Furthermore, the tangible nature of the narratives as written and therefore potentially accessible for re-engagement suggests much scope for developing interventions that may further consolidation of the therapeutic process as well as desensitisation.

To conclude, I propose that narrative as a therapeutic concept may be highly useful for trauma treatment as it may help to address the complex impact trauma has on the memory and on the information-processing capacity of survivors. The findings from this thesis affirm this notion and I suggest that utilising narrative through creative and embodied means indeed supported my ability to articulate and consolidate the therapeutic process. However, literature referring to narrative as a therapeutic concept in DMP is limited to date in relation to treatment of trauma. The current findings indicated that narrative may be constructed through creative movement exploration and have the ability to access embodied tacit knowledge, as proceeding verbal articulation. Engaging with such a process and witnessing the impact it had on me as a survivor of trauma, I highlight here that narrative can be a highly useful therapeutic component for this client group, due to the possibilities of utilising and combining both verbal and non-verbal means. I offer this notion as a potentially relevant and applicable concept that is currently under-researched and which may have the potential to advance DMP practice for the treatment of trauma.

8.4.4 Ritual

The concept of ritual was suggested by participants as having a particular relevance to treatment of trauma despite limited references as such in DMP literature. More specifically, ritual as a therapeutic concept was used creatively by the participants to facilitate and encourage transformation and resolution of trauma experiences. For example, ritual was suggested to potentially enable clients to re-define their perceived identity and move away from the role of the victim. Van Gennep (1960) theorised this concept and framed the notion of the rites of passage, by which ritual is used as to shift, or transform, from one state to another. For example, marriage was perceived as a rite of passage by which the person marrying was shifting from a bachelor status to a married one and so changes their social and cultural position (van Gennep, 1960). The participants discussed different ways by which ritual was utilised in their clinical practice with survivors of trauma and it seemed that as a concept it was broadly interpreted. Analysis revealed that ritual was used as an intervention to end sessions, as a ceremonial element as part of group work as well as a conceptual and therapeutic tool utilised for intentional re-enactment and resolution of trauma. For example, use of ritual in DMP potentially enabled the client to reclaim their sense of self and perhaps also functioned as a rite of passage by supporting relative resolution of the trauma through the use of props.

As a finding from the inquiry, the performance functioned as a ritual which and lent the event a symbolic meaning; for example, it was used to further my relative resolution of trauma and recovery, as part of a therapeutic process. It became apparent to me that the act of personal exposure and 'coming out' with regards to my own traumatic history was to facilitate my process and the preparation that was involved, I argue, contributed much in transforming the performance into a ritual. Turner (1977) elaborated upon the idea of liminality as a metaphorical space that exists before and during the rite of passage, and describes the place a person is in which is neither the previous state, nor in the preceding one, but in-between. In other words, the liminal space acts as a threshold that connects different and adjoining worlds but is neither, nor does it refer to a specific length of time before the ritual is undertaken (Turner, 1977). Harris (2009) emphasised the therapeutic role that ritual can play for survivors of trauma in the context of DMP and suggested that new meanings can be formed in the liminal space that is the preparation for the ritual, seen as key for clients' subsequent transformations. The findings from the inquiry indeed support this notion; the space that was created in preparation of the performance allowed me to better understand what the ritual meant in the context of my

therapeutic process. Therefore, liminality acted as an important factor in my overall process as it enabled me to clarify the trauma effect I was seeking to undo and the appropriate means to achieve this by. I hypothesise that the performance on its own will have had some impact in terms of my personal transformation process as well as relative resolution of trauma. However, I argue that consciously engaging with the concept of ritual in fact created the liminal space in which I was immersed prior to the performance, and which enhanced and supported my personal rite of passage and consequent resolution of trauma. From a DMP perspective, I highlight the embodiment of the ritual, i.e. the physical act of journeying through the therapeutic landscape, which had a symbolic meaning and was therefore effective in enhancing my process.

The findings from this thesis highlight that ritual may take different forms and serve varied functions, and I present it here in accordance with notions of individuality of clients as well as the therapist's not-knowing, as previously discussed. For example, following available literature I would not have anticipated my ritual to take the form of a performance, or that my own trauma stories would have been shared so that I may connect with my vulnerability. The present findings differ from the ways in which ritual has been previously discussed in the literature. Johnson and Lubin (2015), for example, make a direct link between narrative and ritual in relation to creative and embodied psychotherapeutic means and suggest that trauma narratives may be used as tangible objects which can be buried or burnt as part of a transformative ritual. This suggestion was offered as means for resolution and release of the traumatic experiencing and a way to let go of the past (Johnson & Lubin, 2015). However, the purpose of my ritual was not letting go of my history but embracing and accepting it, which in turn enabled me to accept and forgive myself. I use this example to emphasise here the gap that potentially exists between theory and practice in trauma-informed clinical literature, whereby methods of treatment are described in a way which does not always allow for transferability and adjustments. It appears that relevant literature tends to semantically define ritual as having a specific or pre-designed meaning and purpose (Harris, 2009; Johnson & Lubin, 2015), which I highlight may potentially restrict its use in clinical practice. In other words, following the publications which pre-defined the form and purpose of ritual in treatment of trauma would have constricted my use of this concept during the heuristic inquiry. For example, I did not wish to destroy my past or the memories of the trauma – which I would have potentially attempted had I followed the guidance offered in the literature. Following the heuristic inquiry, however, allowed me discover my own needs which were to make peace with my traumatic history. This understanding as a finding led

me to advocate the ways by which ritual may be undertaken creatively and on an individual basis, if it is indeed to fulfil its purpose.

Overall, the findings presented here indicate that the scope of this therapeutic concept may be further investigated theoretically and practically. Boas (2006) asserted that research is needed to determine the function that rituals may fulfil in DMP practice, suggesting it is a therapeutic tool that is often used in this modality and therefore may benefit from further theorising. According to the present findings I propose that the intention I held during the preparation, or liminal stage, was a key to ensure that the ritual indeed had the desired transformative results in the context of the therapeutic process. Therefore, if a ritual was to be included in a trauma-informed DMP framework, based on these findings I suggest it was to be integrated or influenced by notions of the individuality of clients.

8.4.5 Joy

The findings suggested that the experience of joy as part of the therapeutic process was a landmark and an indication of positive change. In the performance, this concept represented my capacity to heal from the impact of the trauma and I considered it an important therapeutic component despite the fact it was also a challenging process and a difficult element to facilitate. Joy as a therapeutic concept has been rarely referred to as such in professional literature. More commonly, DMP and the other creative arts therapies' literature tends to use the term play, which was suggested by Gordon (2014) as under-researched in spite of its recognised significance as a therapeutic and developmental factor. Winnicott (1971) asserted that experiencing play in infancy supports the formation of one's sense of self. According to Cassidy et al. (2017), being allowed to play as part of the therapeutic process was seen to enable clients to connect to their creativity and explore new ways of being and doing, leading to the clients' perceived positive results of the therapy. Based on these notions I suggest that play can indeed evoke feelings of joy, and that joy stands at the heart of many positive experiences. A perceived benefit that DMP treatment had for survivors of trauma was being given a permission to play, which was found to have supported the clients to engage better in interpersonal relationships and increased integration of their sense of self (Mills & Daniluk, 2002). I propose that based on the present findings, joy is closely related to the concept of play as referred to in the literature. The findings in this thesis highlighted the importance of experiencing joy in relation to the

processing of trauma, whereby it simultaneously indicated positive change and was perceived to have furthered it.

I suggest here that trauma also decreases the capacity for positive emotions and particularly if a form of dissociation took place, which will inevitably have a restrictive impact on the emotional system as a whole. Therefore, the ability to experience joy can potentially be linked with the ability to feel fear, shame and anger, for example. Relevant literature suggests that in the aftermath of trauma, survivors may attempt to avoid negative emotions that can trigger trauma-related memories and as a consequence their emotional capacity is reduced, including tolerance for positive experiences (Ogden, Minton & Pain 2006; Johnson & Lubin, 2015; McFarlane, 2017). As a clinical consideration for DMP, this means that as processing of trauma can indeed confront the clients with painful memories and unwanted negative emotions, it may also inhibit the ability of clients to feel joy, if avoidance is used as coping mechanism. According to the interviews, the capacity to feel joy was advocated as supportive of the therapeutic process. However, during the inquiry and when confronted with traumatic memories, the attempts to connect with the experience of joy was at times overwhelming for me. It was not until the later stages of the process, when some trauma processing took place and recovery was already progressing, that I found my way back to joy and was able to understand its significance to the therapeutic process and from a DMP perspective. For example, an indicator to my ability to experience joy was linked with my ability to dance freely, whereby I was not able to do so from the beginning of the inquiry up till that point in time. I propose that joy is an under-researched concept and that limited knowledge is available regarding its role in trauma-informed DMP. According to the findings, I suggest that there is a possibility that once attained, embodiment of joy may potentially act to support clients' management of difficult experiences in therapy as well as in everyday life.

I present the concept of joy here as the final component of the therapeutic process, as primarily found on my own journey through the therapeutic landscape. I highlight that, as the final therapeutic concept that was elucidated in this research, it may also benefit from further investigation to establish its possible value to trauma-informed DMP. However, I attempted to close the hermeneutic circle with this theme of joy, which represented an optimised conclusion to my journey through the therapeutic landscape. Furthermore, I propose that better understanding of joy as a therapeutic concept may elucidate the potential contribution DMP can make for treatment of survivors of trauma.

8.5 Recommendation for DMP practice

The findings from this thesis illustrated that current DMP practice for treatment of trauma is more developed than the state of the art suggests, as reflected in available and relevant literature. The main recommendation I therefore make here is to continue to develop a trauma-informed DMP approach that could incorporate the findings from this thesis into a cohesive framework. For that aim I also propose that further exploration may be beneficial to support theorising DMP for this client group and bring theory and practice closer together.

Notions such as the individual needs of clients and the importance of the therapeutic relationship were found to be well established in the interviews, and yet consideration could be given to further adapt these concepts to the specific and varied contexts of traumatic experiences. I also recommend further exploration of the concepts of narrative and ritual, as well as joy, which were identified in this thesis as helpful for this client group. I propose that the possible implication and value of both these therapeutic concepts potentially exceed that which is currently referred to in DMP literature. My understanding is that the idea of embodied narratives which may be accessible non-verbally may be highly useful for working with survivors of trauma. More specifically, this conceptualisation of narrative may prove as relevant in relation to the difficulties clients may have in articulating their accounts of traumatic history. The findings that highlighted ritual as a component of the therapeutic process suggested it may be used with this client population beyond a regular starting and ending point in sessions. For example, the findings here indicated ritual may be useful to consolidate therapeutic transformation and be utilised as an intentional and attainable land mark in the therapeutic process. Finally, I suggest that the importance of joy and its implications to the process of survivors of trauma may be further considered by DMP practitioners. The findings here emphasise joy as supporting of recovery and perhaps helpful in increasing the affect-regulation capacity with clients. However, further practice-based investigation is required to ascertain the means by which joy may be intentionally facilitated.

With these recommendations, founded on the findings from this thesis, I highlight an initial direction in which a trauma-informed DMP framework may be constructed and founded on creative and embodied means.

8.6 Evaluating the quality of the study: trustworthiness

This section refers to the means through which I attempted to meet the different criteria of trustworthiness outlined earlier in this thesis (see Chapter 3: Methodology) and which I utilised to ensure this study is of a high-quality standard. I also present here reflections on potential avenues through which this thesis could have been further improved and elevated.

Credibility (Lincoln & Guba, 1985) was supported in this research through the methods used for data collection and analysis methods, which enabled a separation between the data, the analysis process and subsequent findings and conclusions. Following a hermeneutic phenomenology stance meant that the final findings were firmly founded in my own interpretation and meaning-making processes. The use of the methods employed (i.e. IPA and the heuristic inquiry) enabled a framework which allowed me to own my findings as idiographic and contextualised understandings. Utilising IPA provided a clear outline of the process I undertook from data to conclusion (see Appendices A+I). In the heuristic inquiry a reflective log was kept as well as a video documentation procedure that was in place (see Appendices I) to record my process. However, my meaning-making processes that led to formulating and conceptualising the final understandings that are presented in this thesis can be traced backwards to the raw data from the interview transcripts. This clarity and transparency of process thus ensures that the findings are credible and that standards of qualitative research were met. Had the timeframe allowed it, it may have been useful to hold a second interview with the participants in which the focus could have been on the final set of findings. This could have enabled further clarity of some of the identified themes as well as supporting the overall credibility of the research.

Dependability (Lincoln & Guba, 1985) was ensured through the level of detail by which the research procedures were described. The accompanying documents which were part of the data collection can be found in the appendices and include the recruitment letter and interview schedule, as well as demographic data and contextual information. The details of the data analysis were also explained at length, in the methodology chapter as well as in examples given in appendices, and were founded on the IPA approach for data analysis as a replicable work method. Overall, much effort was invested to ensure that sufficient level of information and detail was presented here to make the procedures of this research dependable, which also in turn served to enable clarity and credibility of the presented findings and the interpretation process. Concerning the heuristic inquiry, I argue that it is indeed a process of subjective investigation

which inherent limited dependability. However, as the themes I explored were clearly outlined I argue that standards of dependability were satisfactorily maintained. Nevertheless, having had a co-researcher, for example, who would additionally have explored the therapeutic landscape through creative and embodied means may have served to elevate the dependability of the present findings.

Confirmability (Lincoln & Guba, 1985) was attained through the use of the research methods that are founded on interpretation and subjectivity and therefore required ongoing reflexive consideration. In addition I used the support of my advisory team, who acted as external reviewers by examining the data collection and analysis procedures and giving their perspectives on possible meanings emerging from the data. Transparency (Yardley, 2000) has been attempted through the detailed articulation of the research rationale and procedures as seen in this thesis. Furthermore, the use of reflexivity (Etherington, 2007) was maintained in the thesis to ground the findings in my own process of meaning-making and make transparent my various interpretations of the data. This, for example, included linguistic use of the first person to communicate my meaning-making processes as separate from the accounts given by the participants, to avoid generalisation and enhance my ownership over my emerging understandings in relation to the research topic. Due to limited resources I have only presented my research at a few conferences and I propose that doing so a larger extent would have been beneficial to support confirmability further, through an enhanced exposure to feedback.

Transferability (Lincoln and Guba, 1985) in this thesis was attempted through the conceptualisation of the findings as therapeutic concepts which may be applicable and transferable to other psychotherapeutic modalities. Therefore, the naming and phrasing of the findings, as well as all accompanied explanations, were done with the aim for it to be transferable beyond the DMP profession. Indeed, in this thesis I focused on DMP for trauma treatment, due to my own training and personal and professional framing as well as interest and preferences. However, my aim was to disseminate the findings in a fairly transferable form in order to increase the chance that practitioners from different backgrounds and frameworks will find these findings applicable in their practice with survivors of trauma. A useful way to further confirm transferability would have been, for example, a focus group with therapists from different modalities. While beyond the scope of this thesis, such a group could have been used to ascertain the degree by which the identified components of the therapeutic process are applicable to other therapists.

8.7 Limitations of this thesis

Qualitative research is often used to capture the subjective experiences of the research participants through translating these experiences into words (Teddlie & Tashakkori, 2009). Phenomenology as a methodology is concerned with understanding the meaning of phenomena through investigating lived experiences, as perceived by research participants (Smith, Flowers & Larkin, 2009). The aim of this research was to better understand the therapeutic process for trauma in DMP and its components, for which lived experiences of therapists were identified as means to access this phenomenon. As a result, I deemed hermeneutic phenomenology methodology as appropriate to investigate this topic. However, one of the critiques of qualitative research is that the findings cannot be generalised and are therefore not conclusive (Creswell & Plano Clark, 2011). Furthermore, the hermeneutic paradigm is founded on the researcher's subjective interpretation and own experiences and while the methods used in this research offer structured and established guidelines to enhance trustworthiness (Lincoln & Guba, 1985), in such cases and according to Teddlie and Tashakkori (2009), the findings may still be referred to as anecdotal.

Therefore, while advocating the merits of hermeneutic phenomenology as a well suited methodology in the context of this thesis, I also suggest that interpretation as a main epistemological tool has clear limitations. More specifically, my interpretation and meaning-making processes were incorporated by various variables which in turn influenced me during the analysis. For example, my interpretation was likely to have been impacted by my background as a DMP practitioner, which meant I was particularly sensitive to notions of embodiment and creativity. This may be considered as a limitation of the research that I did not attempt objectivity but instead incorporated my subjective and contextual lens in my meaning-making process. However, I suggest that this is generally the case with human beings, that in effect they cannot step outside their own context, by which all sense-making processes are informed (van Manan, 2016). Following this notion, consideration was given to the contextual differences that existed between the literature, the participants, and me. Such differences include, for example, native language, cultural background and clinical orientation, to name but a few. As asserted by Gadamer (1977), it was expected and accounted for that the original meaning will never be quite the same as the resulting understanding. I propose this notion of subjective understanding as a limitation which has impacted this research and its consequent findings. Moreover, I highlight

here that subjectivity may also be regarded as a human limitation which, with the lack of a better solution, should be accepted as inevitable and acknowledged as an underlying ontological and epistemological assumption guiding this PhD.

The findings presented in this thesis are indeed subjective as is the case with qualitative research and I do not claim these to be objective or generalised in any way. This indeed limits the scope and applicability of the identified therapeutic components. In addition, the fact that the findings are primarily founded on the perceptions of therapists means that the clients' side of the therapeutic story was not told in full. While I undertook the therapeutic process as part of the heuristic inquiry and told my story as the client, there are still elements that need further elucidation in the context of clinical work. I propose that there is need for further research to establish a solid and practice-based foundation for the findings identified here to evidence their potential efficacy and value for survivor of trauma as well as to practitioners from DMP background as well as other psychotherapeutic modalities.

8.8 Future research

While I advocate the findings from this thesis as potentially setting a foundation to structure a trauma-informed DMP treatment approach, further research is needed in order to establish an appropriate and effective framework. I propose that the next stage of research will further explore and evaluate the identified therapeutic components in the context of clinical practice. It may be useful to conduct a qualitative investigation of the map of the therapeutic process in clinical settings with survivors of trauma, to perceive its potential value from the perspective of the clients. In addition, an experiential focus group with DMP practitioners may also be carried out to further examine the therapeutic components from a professional perspective. Furthermore, the components may also be investigated on a stand-alone basis to answer questions of therapeutic cause and effect, and particularly with emphasis on the efficacy of specific components for different types/histories of trauma. More specifically, it would be highly useful to link specific interventions and therapeutic elements as beneficial to different types of trauma, as currently there is limited knowledge of the relationship between the two. I suggest that a more precise categorisation of the components of the therapeutic process in relation to different traumatic histories may serve to highlight the contribution of DMP to the treatment of trauma.

To conclude, the conceptualisation of the current findings as a map of a DMP therapeutic process for trauma is brought here as a suggestion that is founded on my own process of investigation and meaning-making, which may support development of current practice. I highlight that this conceptualisation is by no means regarded as finalised but rather as a starting point for a new and innovative way to perceive trauma treatment in the context of DMP. My aim is for the findings that are identified here to be further researched so that both process and components may be better understood, in order to enhance current DMP clinical practice and knowledge, as well as the treatment available for survivors of trauma.

8.9 Conclusion

To conclude, psychological trauma is a highly complex condition which has negative, long-term and chronic effects and has long posed a challenge for psychotherapeutic treatment. In this thesis I argue that trauma-informed DMP is an under-researched area and published knowledge that can elucidate the construct of the therapeutic process and its components as practiced with this client group is currently limited. In this research study I set out to investigate DMP for trauma as well as relevant BP clinical practice so that I can better understand how these approaches are used to treat survivors of traumatic experiences. In order to do so, I decided to explore the therapeutic process and identify its individual components, and to communicate these in a transferable form so that the knowledge gained may be used beyond DMP as a modality. A review of the literature highlighted an agreement on the potential benefits DMP and BP may have for treatment of this client group. The review also indicated a gap in the literature concerning a lack of an established DMP framework for the treatment of this client population. In addition, this gap identified limited discussion on the relationship between specific traumatic histories and the clinical interventions used to treat them. In response to this gap, hermeneutic phenomenology was employed as a methodology that I deemed appropriate to investigate this topic, and two strands of research methods were utilised. Semi-structured interviews with DMP and BP practitioners resulted with a rich and comprehensive grasp of the therapeutic process and its components, as well as the understanding that clinical work with survivors of trauma is conceptually individualised and complex. Due to the volume and richness of the findings from the interviews, I then gathered the identified and relevant therapeutic components and embodied them in a creative line of heuristic inquiry in order to gain in-depth and synthesised understandings of their possible meanings.

Uncovering the core constituents of the therapeutic process revealed an innovative conceptualisation of trauma treatment that was drawing on, and relevant to current DMP practice. I highlight in particular the concepts of witnessing, narrative, ritual and joy that I found to have supported the processing, integration and relative resolution of trauma experiences. The result of this research concluded with a map of the therapeutic process which contained central elements of trauma treatment. I propose that presenting the findings in the form of a map encompasses the non-liner and individualised nature of psychotherapeutic processes. Furthermore, conceptualising the findings as a map also accounts for creative and spatial considerations that are in line with DMP as a modality as well as contributing to its current knowledge. In other words, this final form of dissemination was designed to be used in DMP context whilst remaining potentially applicable to other modalities (e.g. BP and the creative arts therapies). The components are presented as therapeutic concepts to increase transferability and are therefore meant to be open to adaption and interpretation according to individual, professional and clinical preferences. This map is still to be investigated and evaluated further in clinical setting. Overall, it is an initial step on the path to consolidate and evidence the unique contribution the DMP can make to trauma treatment.

Conceptualising the therapeutic process as a map, I believe, captures the spirit of creative discovery required to engage with therapy and, as such, may help clients survivors of trauma traverse their challenging journey through their internal landscape.

References

ADLER, J. 2002. *Offering from a Conscious Body: The Discipline of Authentic Movement*. Vermont: Inner Traditions

ADLER, J. 2007. From seeing to knowing. In: Pallaro, P. (Ed). *Authentic movement: moving the body, moving the self, being moved – A collection of essays, Volume 2*. London: Jessica Kingsley Publishers. 260-269

AMERICAN PSYCHIATRIC ASSOCIATION. 2013. *Diagnostic and statistical manual of mental disorders: DSM-5* (5th ed.). Washington, D.C: American Psychiatric Publishing.

ALLEGRANTI, B. 2013. The politics of becoming bodies: Sex, gender and intersubjectivity in motion. *Arts in Psychotherapy*. [online] Vol. 40, issues 4, pp. 394-403 /doi.org/10.1016/j.aip.2013.05.017 [accessed 12/11/2014]

AMIR, D. 2012. The inner witness. *The International Journal of Psycho-Analysis*, [online] 93(4), 879-896. doi.org/10.1111/j.1745-8315.2012.00618.x [accessed 3/12/2014]

AMONE-P'OLAK, K. 2006. Mental states of adolescents exposed to war in Uganda: Finding appropriate methods of rehabilitation. *Torture*. 16, 93-107

ARIZMENDI, T. G. 2008. Nonverbal communication in the context of dissociative processes. Psychoanalytic Psychology, [online] 25(3), 443-457. doi10.1037/0736-9735.25.3.443 [accessed 19/11/2011]

ATARIA, Y. 2014. Traumatic memories as black holes: A qualitative-phenomenological approach. Qualitative Psychology, [online] 1(2), 123-140. doi10.1037/qup0000009 [accessed 26/2/2016]

ATIRA TAN, L. 2012. Art therapy with trafficked women. *Therapy Today*. [online] 23 (5), 26-31. doi a1CG0000000GM3cMAG [accessed 3/3/2015]

BALABAN, V. 2009. Assessment of children. . In: FOA, E., KEANE, T., FRIEDMAN, M. and COHEN, J. (Eds). Effective treatment for PTSD: Practice guidelines from the international society for traumatic stress studies. NY: The Guilford Press. Pp. 62-81

BAUM, R. 2009. Surviving Absence: Preliminary Findings on Dance Therapy and War Trauma. In DUMPHY, K. GUTHRIE, J. and LOUGHLIN, E. eds. *Dance Therapy Collections No. 3*. VIC: Dance Therapy Association of Australia, pp. 118-126

BAUM, R. 2013. Transgenerational trauma and repetition in the body: The groove of the wound. *Body, Movement and Dance in Psychotherapy*, [online] 8(1), 34-42. doi10.1080/17432979.2013.748976 [accessed 13/10/2014]

BEN-DAVID, V., and JONSON-REID, M. 2017. Resilience among adult survivors of childhood neglect: A missing piece in the resilience *Children and Youth Services Review.* [online] Vol. 78, pp. 93-103. doi.org/10.1016/j.childyouth.2017.05.014 [accessed 25/3/2018]

BENISH, S. G., IMEL, Z. E., and WAMPOLD, B. E. 2008. Corrigendum to "The relative efficacy of bona fide psychotherapies for treating post-traumatic stress disorder: A meta-analysis of direct comparisons". *Clinical psychology review.* [online] 28(7), 1281-1299. doi10.1016/j.cpr.2008.06.001 [accessed 3/12/2014]

BENSIMON, M., AMIR, D. and WOLFW, Y. 2012. A pendulum between trauma and life: Group music therapy with post-traumatized soldiers. *The Arts in Psychotherapy*, [online] 39(4), 223-233. doi 10.1016/j.aip.2012.03.005 [accessed 13/4/2015]

BERRIOS, G. E. 1989. What is phenomenology? A review. *Journal of the Royal Society of Medicine,* [online] 82(7), 425-428. doi 10.1016/0010-440X(93)90001-K [accessed 5/8/2015]

BERNSTEIN, P. L. 1979. *Eight theoretical Approached in Dance – Movement Therapy*. Iowa: Kendall/Hunt Publishing Company

BISSON, J., and ANDREW, M. 2007. Psychological treatment of post-traumatic stress disorder (PTSD). *The Cochrane Database of Systematic Reviews*, (3), CD003388.

BOAS, S. 2006. The body of culture: transcultural competence in dance movement therapy. In: PAYNE, H. (Ed). *Dance movement therapy: theory, research and practice (2nd ed)*. USA: Routledge. Pp.112-131

BOBER, T., REGEHR, C., and ZHOU, R. 2006. Development of the Coping Strategies Inventory for Trauma Counselors. *Journal of Trauma and Loss*, [online] 11, pp. 71–83. doi/abs/10.1080/15325020500358225 [accessed 8.2/2016]

BORRETT, D. S., and KWAN, H. C. 2008. Understanding understanding: An evolutionary autonomous agent approach. *Review of General Psychology*, [online] 12(2), 137-146. doi 10.1037/1089-2680.12.2.137 [accessed 11/10/2014]

BRADLEY, R., GREENE, J., RUSS, E., DURTA, L., and WESTEN, D. 2006. 'A multidimensional meta-analysis of psychotherapy for PTSD': Correction. *The American Journal of Psychiatry*, [online] 163(2), pp.312-330. doi 10.1176/appi.ajp.163.2.330 [accessed 8/10/2014]

BRETT, E. A. 2007. The classification of posttraumatic stress disorder. In: VAN DER KOLK, B., MCFARLANE, A. and WEISAETH, L. *Traumatic stress: the effects of overwhelming experience on Mind, Body and Society*. 2nd edition. NY: The Gilford Press. Pp. 117-128

BRIERE, J., and SPINAZZOLA, J. 2005. Phenomenology and psychological assessment of complex posttraumatic states. *Journal of Traumatic Stress*, [online] 18(5), pp. 401-412. doi10.1002/jts.20048 [accessed 16/6/2017]

BUGGE, K. E., HAUGSTVEDT, K. T. S., RKHOLT, E. G., DARBYSHIRE, P., and HELSETH, S. 2012. Adolescent bereavement: Embodied responses, coping and perceptions of a body awareness support programme. *Journal of Clinical Nursing*, [online] 21(15-16), pp. 2160-2169. doi10.1111/j.1365-2702.2012.04141.x [accessed 2/3/2015]

CAHILL, S., ROTHBAUM, B., RESICK, P. and FOLLETTE, V. 2009. Cognitive –behavioral therapy for adults. In: FOA, E., KEANE, T., FRIEDMAN, M. and COHEN, J. (Eds). *Effective treatment for PTSD: Practice guidelines from the international society for traumatic stress studies*. NY: The Guilford Press. Pp. 139-222

CALLAHAN, A, 2011. The parent should go first: a dance/movement therapy exploration in child loss. *American Journal of Dance Therapy.* [online] 33, pp. 182-195. doi10.1007/s10465-011-9117-3 [accessed 5/8/2015]

CARDENA E, MALDONADO, J.R., VAN DER HART, O. and SPIEGEL, D. 2009. Hypnosis. In: FOA, E., KEANE, T., FRIEDMAN, M. and COHEN, J., (Eds). *Effective treatments for PTSD: Practice Guidelines from the International Society for Traumatic Stress Studies*. 2nd ed. New York: Guilford Press. Pp. 427–457.

CARR, C., D'ADRENNE, P., SLOBODA, A., SCOTT, C., WANG, D. and PRIEBE, S. 2012. Group music therapy for patients with persistent post-traumatic stress disorder: An exploratory randomized controlled trial with mixed methods evaluation. *Psychology and Psychotherapy: Theory, Research and Practice*, [online] 85(2), pp. 179-202. 10.1111/j.2044-8341.2011.02026.x [accessed 2/3/2015]

CARUTH, C. 1995. Introduction. In CARUTH, C. (Ed.), *Trauma: Explorations in memory*. Baltimore, MD, US: Johns Hopkins University Press. Pp. 3-12

CASSIDY, S., GUMLEY, A., and TURNBULL, S. 2017. Safety, play, enablement, and active involvement: Themes from a grounded theory study of practitioner and client experiences of change processes in dramatherapy *The Arts in Psychotherapy* [online] 55, pp. 174-185. /doi.org/10.1016/j.aip.2017.05.007 [accessed 30/8/2018]

CAVALLI, A. 2012. Transgenerational transmission of indigestible facts: From trauma, deadly ghosts and mental voids to meaning-making interpretations. *Journal of Analytical Psychology*, [online] 57(5), pp. 597-614. 10.1111/j.1468-5922.2012.02005.x [accessed 20/12/2016]

CHANG, M. and LEVENTHAL, F. 2008. Dance/Movement Therapy Interventions in domestic Violence: Still a Paradigm of Action. In: BROOK, S. L. (Ed). *The Use of Creative Therapies with survivors of Domestic violence.* Illinois: Charles C Thomas Publisher, LTD. Pp. 73-101

CHODOROW, J. 1991. *Dance Therapy and Depth Psychology: The moving imagination.* London: Routledge.

CHODOROW, J. 2007. Inner-directed movement in analysis: early beginnings. In: PALLARP, P. (Ed). *Authentic movement: moving the body, moving the self, being moved – A collection of essays, Volume 2*. London: Jessica Kingsley Publishers. Pp. 32-34

CHOI, K. R. 2016. Complex psychological trauma and self-dysregulation: A theory synthesis for nursing. Research and Theory for Nursing Practice, [online]30(1), pp. 10-25. doi 27024997 [accessed 9/9/2017]

CLARK, J. 2008. Facing the Abuser in the Abused in body Psychotherapy. In: HARTLEY, L. (Ed) *Contemporary body psychotherapy*. London: Routledge. Pp. 154 - 168

CRESPO, M., and FERNANDEZ-LANSAC, V. 2015. Memory and narrative of traumatic events: A literature review. *Psychological Trauma: Theory, Research, Practice and Policy*, [online] 8(2), pp. 149-156. doi10.1037/tra0000041 [accessed 13/12/2016]

CRESSWELL, J., W. and PLANO CLARK, V., L. 2011. *Designing and Conducting Mixed Methods Research.* California: Sage Publications Inc.

CUSACK, K., JONAS, D. E., FORNERIS, C. A., WINES, C., SONIS, J., MIDDLETON, J. C. and GAYNES, B. N. 2016. Psychological treatments for adults with posttraumatic stress disorder: A systematic review and meta-analysis. *Clinical Psychology Review.* [online] Vol. 43, pp. 128-141. //doi.org/10.1016/j.cpr.2015.10.003 [accessed 8/6/2017]

DE TORD, P., and BRAUNINGER, I. (2015). Grounding: Theoretical application and practice in dance movement therapy. *The Arts in Psychotherapy*. [online] 43(1). Pp.16-22. doi.org/10.1016/j.aip.2015.02.001 [accessed 30/8/2016]

DE VALENZUELA, M. 2014. Dancing with mothers: A school-based Dance/Movement Therapy group for Hispanic immigrant Mothers. *American Journal of Dance Therapy.* [online] 36, pp. 92-112. doi10.1007/s10465-014-9166-5 [accessed 3/12/2014]

DEBESAY, J., NADEN, D., & SLETTEBO, R. 2008. How do we close the hermeneutic circle? A Gadamerian Approach to Justification of Interpretation in Qualitative Studies. *Nursing Inquiry*, [online] 15(1), pp. 57-66. doi2009801717x [accessed 1/6/2017]

DEVEREAUXD, C. 2008. Untying the knots: Dance/movement therapy with a family exposed to domestic violence. *American Journal of Dance Therapy*, [online] 30(2), pp. 58-70. doi.org/10.1007/s10465-008-9055-x [accessed 14/1/2010]

DIETERICH-HARTWELL, R. 2017. Dance/movement therapy in the treatment of posttraumatic stress: A reference model. *The Arts in Psychotherapy*. [online] Vol. 54, pp.38-46. //doi.org/10.1016/j.aip.2017.02.010 [accessed 2/2/2018]

DOKTER, D. 2010. Embodying difference: to join or not to join the dance. In: JONES, P. (Ed). *Drama as therapy: Vol 2, Clinical work and research into practice.* USA: Routledge. Pp.208-223

DOKTER, D. and WINN, L. 2011. Evaluating Dramatherapy. EBP and PBE: A Research Project. *Dramatherapy*. [online] Vol. 31, No. 1. Pp. 3-9. doi.org/10.1080/02630672.2017.1288263 [accessed 1/6/2017]

DOWNE, S., FINLAYSON, K., Walsh, D., and LAVENDER, T. 2009. 'Weighing up and balancing out': A meta-synthesis of barriers to antenatal care for marginalised women in high-income countries. *BJOG: An International Journal of Obstetrics and Gynaecology*, [online] 116(4). Pp. 324-331. doi 10.1111/j.1471-0528.2008.02067 [accessed 12/7/2015]

DRUMMOND, J. J. 2007. Phenomenology: Neither auto - nor hetero - be. *Phenomenology and the Cognitive Sciences*, [online] 6(1), pp. 221-236. 10.1007/s11097-006-9037-8 [accessed 9/6/2017]

DUBE, S. R., DONG, M., CHAPMAN, D. P., GILES, W. H., ANDE, R. F., and FELITTIF, V. J. 2003. Childhood abuse, neglect, and household dysfunction and the risk of illicit drug use: The adverse childhood experiences study. *Paediatrics*, [online] 111(3), pp. 564-572. doi10.1016/j.aip.2010.07.003 [accessed 12/12/2014]

DUNPHY, K., ELTON, M., and JORDAN, A. 2014. Exploring dance/movement therapy in post-conflict Timor-Leste. *American Journal of Dance Therapy*, [online] 36(2), pp. 189-208. 10.1007/s10465-014-9175-4 [accessed 12/11/2015]

EDWARDS, J., 2015. Sites of knowledge and knowing. *Arts in psychotherapy*. [online] Vol. 43, pp. A1-A1. dx.doi.org.edgehill.idm.oclc.org/10.1016/j.aip.2015.05.001 [accessed 24/9/2017]

EHLERS, A., and CLARK, D. M. 2000. A cognitive model of posttraumatic stress disorder. *Behaviour Research and Therapy*. [online] Vol 38, Issue 4. Pp. 319-345. //doi.org/10.1016/S0005-7967(99)00123-0 [accessed 18/5/2018]

EIDEN, B. 2009. The roots and development of the Chiron approach. In: HARTLEY, L. (Ed). Contemporary Body Psychotherapy: The Chiron Approach. East Essex: Routledge. Pp. 63-78

ETHERINGTON, K. 2004. Heuristic research as a vehicle for personal and professional development. *Counselling & Psychotherapy Research, 4*(2), pp. 48-63. 10.1080/14733140412331383973 [accessed 1/2/2018]

ETHERINGTON, K. 2007. Ethical research in reflexive relationships. *Qualitative Inquiry*, [online] 13(5), pp. 599-616. doi: 10.1177/1077800407301175 [accessed 1/2/2018]

ETHERINGTON, K. 2016. Personal experience and critical reflexivity in counselling and psychotherapy research. *Counselling and Psychotherapy Research*, [online]17(2), pp. 85-94. doi.org/10.1002/capr.12080 [accessed 1/2/2018]

EVANS, D. 2003, Hierarchy of evidence: a framework for ranking evidence evaluating healthcare interventions. Journal of Clinical Nursing, [online]12, pp. 77-84. doi.org/10.1046/j.1365-2702.2003.00662.x [accessed 1/8/2018]

FARGNOLI, A. 2017. Maintaining safety in the face of adversity: Self-care practices of human trafficking survivors in India. *American Journal of dance Therapy*. [online] 39, pp.226-251. 10.1007/s10465-017-9262-4 [accessed 2/4/2018]

FELMAN, S. 1992. Education and crisis, or the vicissitudes of teaching. In: FELMAN, S. and LAUB, D. (Eds) *Testimony: the crisis of witnessing in literature, psychoanalysis, and history*. NY: Routledge. Pp. 1-56

FERNANDEZ-LANSAC, V. and CRESPO, M. 2017. Quality of memories in women abused by their intimate partner: Analysis of traumatic and nontraumatic narratives: Trauma memories in abused women. *Journal of Traumatic Stress*, [online] 30(1), pp. 80-87. 10.1002/jts.22154 [accessed 16/7/2018]

FISCHER-LICHRE, E. 2016. The art of spectatorship. *Journal of Contemporary Drama in English*, *4*(1), pp.164-179.

FOA, E., HUPPERT, J., and CAHILL, S. 2006. Emotional Processing Theory: An Update. In: ROTHBAUM, B. O. (Ed.), *Pathological anxiety: Emotional processing in etiology and treatment*. Pp. 3-24. New York, NY, US: Guilford Press.

FOA, E., KEANE, T., FRIEDMAN, M. and COHEN, J. 2009. Introduction. In: FOA, E., KEANE, T., FRIEDMAN, M. and COHEN, J (Eds). Effective treatments for PTSD: practice guidelines from the international society for traumatic stress studies. NY: Guilford Publications. Pp. 1-9

FOSHA, E. 2003. Dyadic regulation and experiential work with emotion and relatedness in trauma and disorganised attachment. In: SOLOMON, M. and SIEGEL, D. (Eds). *Healing trauma: attachment, mind, body and brain*. NY: W.W. Norton & Company, Inc. pp. 221- 281

FOSHA, D. 2013. A heaven in a wild flower: Self, dissociation, and treatment in the context of the neurobiological core self. *Psychoanalytic Inquiry*, [online] 33(5), pp. 496-523. 10.1080/07351690.2013.815067 [accessed 2/12/2014]

FORESTER, C. 2007. Your Own Body of wisdom: Recognizing and working with Somatic Countertransference with Dissociative and Traumatized Patients. *Body, Movement and Dance in Psychotherapy*. [online] 2 (2), pp. 123-133. doi.org/10.1080/17432970701374510 [accessed 13/4/2010]

FRIEDER, S. 2007. Reflections on Mary Starks Whitehouse. In: PALLARO, P. (Ed). *Authentic movement: Moving the body, moving the self, being moved: A collection of essays - volume two*. London: Jessica Kingsley Publishers. 35-44.

FROMMBERGER, U., ANGENENDT, J., and BERGER, M. (2014). Post-traumatic stress disorder--a diagnostic and therapeutic challenge. *Deutsches Ärzteblatt International*, [online] 111(5), 44-59. doi10.3238/arztebl.2014.0059 [accessed 30/4/2016]

GADAMER, H., G. 1977. *Philosophical Hermeneutics*. California: University of California Press

GNATT, L., and TINNIN, L. W. 2009. Support for a neurobiological view of trauma with implications for art therapy. *The Arts in Psychotherapy*, [online] 36(3), 148-153. doi10.1016/j.aip.2008.12.005 [accessed 8/4/2017]

GERGEN, K.J., GERGEN, K.J., JOSSELSON, R. and FREEMAN, M., 2015. The promises of qualitative inquiry. *The American Psychologist*, [online] 70(1), pp. 1-9. doi: 10.1037/a0038597 [accessed 1/5/17]

GERGER, H., MUNDER, T., GEMPERLI, A., NUESCH, E., TRELLE, S., JUNI, P., and BARTH, J. 2014. Integrating fragmented evidence by network meta-analysis: Relative effectiveness of psychological interventions for adults with post-traumatic stress disorder. *Psychological Medicine*, [online] 44(15), 3151-3164. doi10.1017/S0033291714000853 [accessed 13/4/2015]

GILROY, A. 2006. *Art Therapy, Research and Evidence-based Practice*. Sage Publications; London

GLASZIOU, P., IRWIG, L., BAIN, C. and COLDITZ, G. (2001). *Systematic reviews in health care: A practical guide*. UK: Cambridge University Press

GOODRICH-DUNN, B. and GREEN, E. (2001). Voices: a history of Body Psychotherapy. *USA Body Psychotherapy Journal* Vol.1, No. 1. Pp.78-83

GORDON, G. 2014. Well played: The origins and future of playfulness. *American Journal of Play*, [online] 6(2), 234-234. doi files.eric.ed.gov/fulltext/EJ1023802.pdf [accessed 5/6/2017]

GRAY, A. E. 2001. The Body Remembers: Dance/Movement Therapy with an Adult Survivor of Torture. *American Journal of Dance Therapy*. [online] 23(1), 29-43. doi1010780306585 [accessed 27/4/2010]

GRAY, A. E. 2017. Polyvagal-Informed Dance/Movement Therapy for Trauma: A global perspective. American Journal of Dance Therapy, [online] 39(1), pp. 39-43. 10.1007/s10465-017-9254-4 [accessed 10/4/2018]

GREENBERG, L. 2014. The therapeutic relationship in emotion-focused therapy. *Psychotherapy Chicago, Ill*, [online] 51(3), pp. 350-357. 10.1037/a0037336 [accessed 8/5/2017]

GEENWOOD, H. 2011. Long term individual art psychotherapy. Art for art's sake: The effect of early relational trauma. *International Journal of Art Therapy*, [online] 16(1), pp. 41-51. 10.1080/17454832.2011.570274 [accessed 2/3/2015]

GRIX, J. 2004. *Foundations of research*. NY/London: Palgrave Macmillan Ltd.

GUIGNON, C. 2012. Becoming a person: Hermeneutic phenomenology's contribution. *New Ideas in Psychology*, [online] 30(1), pp. 106-106. doi.org/10.1177/1609406916680634 [accessed 29/6/2017]

HAMMERSLEY, M. 2011. *Methodology: Who needs it?* London: Sage Publications

HAMMERSLEY, R., DALGARNO, P., MCCOLLUM, S., and REID, M. 2016. Trauma in the childhood stories of people who have injected drugs. *Addiction Research & Theory,* [online] 24(2), pp. 135-151. doi: 10.3109/16066359.2015.1093120 [accessed 10/6/2017]

HARRIS, D. A. 2009. The paradox of expressing speechless terror: Ritual liminality in the creative arts therapies treatment of posttraumatic distress. *The Arts in Psychotherapy*, [online] 36(2), pp. 94-104. doi 10.1016/j.aip.2009.01.006 [accessed 1/5/2011]

HARTLEY, L. 2009. *Contemporary body psychotherapy*. London: Routledge.

HARVEY, S. 1995. Sandra: The Case of an Adopted Sexually Abused Child. In: Levy, F.J., Pines fried, J. and Leventhal, F. eds. *Dance and other Expressive Art Therapies: When Words are Not Enough.* NY: Routledge, pp. 167-180

HARVEY, S. T., and TAYLOR, J. E. 2010. 'A meta-analysis of the effects of psychotherapy with sexually abused children and adolescents': Erratum. *Clinical Psychology Review,* [online] *30*(8), pp. 1049-1050. doi 10.1016/j.cpr.2010.07.002 [accessed 9/7/2016]

HEIDEGGER, M. 1978. *Basic Writings: from Being and time (1927) to The Task of thinking (1964).* Oxon: Routledge

HELLER, D. P. and HELLER, L. S. 2002. Somatic Experiencing in the Treatment of Auto Accident Trauma. *The United States Association for Body Psychotherapy* [online] Vol 1(1), pp. 16-20. doi http://www.boazfeldman.com/EN/Links_files/HELLER%20-%20Somatic-Experiencing-with-Auto-Accident-Diane-Poole-Heller%E2%80%A6.pdf [accessed 10/10/2014]

HELMICH, J. 1999. Dance Movement Therapy with Adults Who Experienced Sexual Abuse in Childhood: The Early Phase of Recovery. In: GUTHRIE, J., LOUGHLIN, E. and ALBISTON, D. (Eds.). *Dance Therapy Collections No. 2. VIC: Dance Therapy Association of Australia*, pp. 45-49.

HELMICH, J. 2009. One Man's Experience of Accessing and Transforming Embodied Traumatic Memory: A Dance Therapy Study. In: DUNPHY, K. GUTHERIE, J. and LOUGHLIN, E. (Eds). *Dance Therapy Collections No. 3. VIC: Dance therapy Association of Australia*, pp. 86-97.

HERBERT, C. 2006. Healing from Complex Trauma: An integrative 3-systems' approach. In: CORRIGALL, J., P. PAYNE, H. and WILKINSON, H. (Eds). *About the body: working with the embodied mind in psychotherapy.* New York: Routledge. pp. 139-161

HERMAN, J. L. 1994. *Trauma and Recovery: from domestic abuse to political terror*. 2nd edition, USA: Pandora

HERMAN, J. 2012. CPTSD is a distinct entity: Comments on Resick et al. (2012). *Journal of Traumatic Stress*, [online] 25(3), pp. 256-257. doi 10.1002/jts.21697 [accessed 26/8/2016]

HO, R. T. H. 2015. A place and space to survive: A dance/movement therapy program for childhood sexual abuse survivors. *The Arts in Psychotherapy*, [online] 46, pp. 9-16. 10.1016/j.aip.2015.09.004 [accessed 12/11/2015]

HOLIFIELD, B. 2007. Against the wall, her beating heart: working with somatic aspects of transference, countertransference and dissociation. In: PALLARO, P. (Ed). *Authentic movement: Moving the body, moving the self, being moved: A collection of essays - volume two*. London: Jessica Kingsley Publishers. Pp. 137-153

HOPPER, E. K. 2017. Trauma-informed psychological assessment of human trafficking survivors. *Women & Therapy,* [online] 40(1-2), pp. 12-30. 10.1080/02703149.2016.1205905 [accessed 25/3/2018]

HUDGINS, M., K. 2002. *Experiential treatment for PTSD: The therapeutic spiral model*. New York: Springer.

HUSSERL, E. 1965. Phenomenology and the Crisis of Philosophy. NY: Harper and Row Publishers, Inc.

JANET, P. (1924). *Principles of psychotherapy*. 1st ed. NY: Macmillan Co.

JIRAK, S. L. 2017. Narrative reconstruction and post-traumatic growth among trauma survivors: The importance of narrative in social work research and practice. *Qualitative Social Work*; Vol 16, Issue 2. Pp. 319-336. /doi.org/10.1177/1473325016656046 [accessed 1/6/2017]

JOHNSON, D. R. 2009. Commentary: Examining underlying paradigms in the creative arts therapies of trauma. *The arts in psychotherapy*. [online] Vol. 36, Issue 2, pp. 114-120. /doi.org/10.1016/j.aip.2009.01.011 [accessed 13/7/2010]

JOHNSON, D. R., LAHAD, M., and GRAY, A. 2009. Creative therapies for adults. In FOA, E., KEANE, T. FRIEDMAN, M. and COHEN, J. *Effective treatments for PTSD: practice guidelines from the international society for traumatic stress studies.* New York, NY, US: Guilford Press. pp. 479-490

JOHNSON, D.R. and LUBIN, H. 2015. *Principles and techniques of trauma-cantered psychotherapy*. USA: American psychiatric association

JONES, F., RODGER, S., BOYD, R., and ZIVIANI, J. 2012. Application of a hermeneutic phenomenologically orientated approach to a qualitative study. *International Journal of Therapy & Rehabilitation*, [online] 19(7), pp. 370-378. doi.org/10.12968/ijtr.2012.19.7.370 [accessed 12/12/2016]

JONES, P. 2007. *Drama as therapy Volume 1: theory, practice and research (2nd ed)*. USA: Routledge

JONES, P. 2010. The nature of practice and practitioner research. In: JONES, P. (Ed). *Drama as therapy Volume 2: Clinical work and research into practice*. UK/USA: Routledge pp. 3-20

KARKOU, V. and SANDERSON, P. 2006. Arts Therapies: a research-based map of the field. Edinburgh: Elsevier Churchill Livingstone

KISIEL, C, SUMMERSETT-RINGGOLD, F., WEIL, L., and MCCLELLAND, G. 2017. Understanding strengths in relation to complex trauma and mental health symptoms within child welfare. *Journal*

of Child and Family Studies, [online] 26(2), pp. 437-451. doi10.1007/s10826-016-0569-4 [accessed 25/3/2018]

KO, K.S., 2017. A broken heart from a wounded land: The use of Korean scarf dance as a dance/movement therapy intervention for a Korean woman with haan. *The Arts in Psychotherapy* [online] 55, pp. 64-72. doi10.1016/j.aip.2017.04.002 [accessed 10/5/2018]

KOCH, S. C. 2008. Dance/Movement Therapy with Clergy in Crisis: A (Group) Case Study. *American Journal of Dance Therapy*. [online] 30: 71-83. doi 10.1007/s10465-008-9053-z} [accessed 3/4/2011]

KOCH, S.C. and FISCHMAN, D., 2011. Embodied Enactive Dance/Movement Therapy. American Journal of Dance Therapy, [online] 33(1), 57-72. doi10.1007/s10465-011-9108-4 [accessed 17/9/2015]

KOCH, S. C., and WEIDINGER-VON DER RECKE, B. 2009. Traumatised refugees: An integrated dance and verbal therapy. *The arts in psychotherapy*. [online] Vol. 36, Issue 5. Pp. 289-296. /doi.org/10.1016/j.aip.2009.07.002 [accessed 2/12/2014]

KOCH, T. 1996. Implementation of a hermeneutic inquiry in nursing: Philosophy, rigour and representation. *Journal of Advanced Nursing, 24*(1), pp. 174-184.

KOGAN, I. 2016. My Father, Myself. *The Psychoanalytic Quarterly*, [online] 85(3), pp. 563-587. doi 10.1002/psaq.12086 [accessed 3/4/2017]

KUDLER, H., KRUPNICK, J., BLANK, J., A., HERMAN, J. and HOROWITZ, M. 2009. Psychodynamic therapy for adults. In: FOA, E., KEANE, T., FRIEDMAN, M. & COHEN, J. (Eds). *Effective treatments for PTSD: practice guidelines from the international society for traumatic stress studies*. NY: Guilford Publications. Pp. 346-369

LAC, V. 2016. Gestalt Equine Psychotherapy as Humanistic Play Therapy. *Journal of Humanistic Psychology* [online] Vol 56, Issue 2. Pp. 98-112. doi http://herdinstitute.com/wp-

content/uploads/2016/08/Gestalt-Equine-Psychotherapy-as-Humanistic-Play-Therapy.pdf [accessed 2/8/207]

LAHAD, M., FARHI, M., LEYKIN, D., and KAPLANSKY, N. 2010. Preliminary study of a new integrative approach in treating post-traumatic stress disorder: SEE FAR CBT. *The Arts in Psychotherapy.*[online] 37. Pp 391-399. doi 10.1016/j.aip.2010.07.003 [accessed 26/5/2015]

LANDALE, M. 2009. Working with psychosomatic distress and developmental trauma: a clinical illustration. In: HARTLEY, L. (Ed). *Contemporary Body Psychotherapy: The Chiron Approach*. East Essex: Routledge. Pp. 79-93

LANGMUIR, J., KIRSH, S., & CLASSEN, C. 2012. A Pilot study of Body-Oriented Psychotherapy: Adapting Sensorymotor Psychotherapy for the Group Treatment of Trauma. 2012. *Psychological Trauma: Theory, Research, Practice and Policy*. [online] Vol. 4, No. 2, pp. 214-220. doi10.1037/a0025588 [accessed 15/10/2014]

LAUB, D. 2013. On leaving home and the flight from trauma. *Psychoanalytic Dialogues,* [online] 23(5), pp. 568-580. doi 10.1080/10481885.2013.832602 [accessed 17/10/2015]

LARKIN, M., WATTS, S., and CLIFTON, E. 2006. Giving voice and making sense in interpretative phenomenological analysis. *Qualitative Research in Psychology,* [online] 3(2), pp. 102-120. doi 10.1191/1478088706qp062oa [accessed 3/12/2014]

LEENARTS, L. E. W., DIEHLE, J., DORELEIJERS, T. A. H., JANSMA, E. P., and LINDAUER, R. J. L. 2013. Evidence-based treatments for children with trauma-related psychopathology as a result of childhood maltreatment: A systematic review. *European Child & Adolescent Psychiatry,* [online] 22(5), pp. 269-283. doi 10.1007/s00787-012-0367-5 [accessed 6/8/2017]

LEEN-FELDNER, E. W., FELDNER, M. T., KNAPP, A., BUNACIU, L., BLUMENTHAL, H., and AMSTADTERA, A. B. 2013. *Offspring psychological and biological correlates of parental posttraumatic stress: Review of the literature and research agenda*. [online]33(8), pp. 1106-33. doi.org/10.1016/j.cpr.2013.09.001 [accessed 19/12/2016]

LEITCH, M.L., 2007. Somatic Experiencing treatment with tsunami survivors in Thailand: Broadening the scope of early intervention. Traumatology, [online]13(3), pp. 11-20. doi 10.1177/1534765607305439 [accessed 6/5/2015]

LEVY, F. 2005. *Dance Movement Therapy: A Healing Art*. 2nd ed. Reston, VA: National dance association, an association of the American Alliance for health, Physical Education, Recreation and Dance.

LEVINE, P.A. 2010. *In An Unspoken Voice: How the Body Releases Trauma and Restores Goodness*. California: North Atlantic Books.

LINCOLN, Y. S. and GUBA, E. G. 1985. *Naturalistic Inquiry*. California: Sage publications Inc.

LINGE, D. 1977 Introduction. In: GADAMER, H., *1900-2002*. *Philosophical hermeneutics*. USA: University of California Press

LITVACK, A. MISHNA, F. and BOGO, M. 2010. Emotional reactions of Students in Field Education: An Exploratory Study. *Journal of Social Work Education*. 46 (2), pp. 227-243.

LOBBAN, J. 2014. The invisible wound: Veterans' art therapy. *International Journal of Art Therapy*, [online] 19(1), pp. 3-18. 10.1080/17454832.2012.725547 [accessed 2/3/2015]

LOPEZ, G. 2011. Why verbal psychotherapy is not enough to treat Post Traumatic Stress Disorder: a Biosystematic approach to stress debriefing. *Body, Movement and Dance in Psychotherapy*. [online] Vol. 6, No. 2, pp. 129-143. doi.org/10.1080/17432979.2011.583060 [accessed 14/10/2014]

LYDDON, W. J. 1995. On the relation between philosophical worldviews and theories of counselling and development: A comment. *Journal of Counselling & Development*, *73*(5), pp. 515-517.

LYSHAK-STELZER, F., SINGER, P., ST JOHN, P., and CHAMTOB, C. M. 2007. Art therapy for adolescents with posttraumatic stress disorder symptoms: A pilot study. *Art Therapy*, [online] 24(4), pp. 163-169. 10.1080/07421656.2007.10129474. [accessed 13/5/2015]

MACDONALD, J. 2006. Dancing with Demons: Dance movement Therapy and Complex Post-traumatic Stress Disorder. In: PAYNE, H. (Ed). *Dance Movement Therapy: Theory, Research and Practice.* 2nd ed. London: Routledge. Pp. 49-70.

MACINTOSH, H. B. 2003. Sounds of healing: Music in group work with survivors of sexual abuse. *The Arts in Psychotherapy*, [online] 30(1), pp. 17-23. 10.1016/S0197-4556(02)00229-0 [accessed 8/4/2017]

MCFARLANE, A. 2017. Post-traumatic stress disorder is a systemic illness, not a mental disorder: Is Cartesian dualism dead?. *The Medical Journal of Australia*. [online] 206. Pp. 248-249. doi 10.5694/mja17.00048 [accessed 1/8/2017]

MCFARLANE, A. and GIROLAMO, G. 2007. The nature of traumatic stress and the epidemiology of posttraumatic reactions. In: VAN DER KOLK, B., MCFARLANE, A. and WEISAETH, L. (Eds) *Traumatic stress: the effects of overwhelming experience on Mind, Body and Society (2nd ed)*. NY: The GilfordPress. Pp. 129-154

MERLEAU-PONTY, M. 1962. *Phenomenology of Perception*. England: Routledge publications.

MEEKUMS, B. 1999. A creative model for recovery from child sexual abuse trauma. *The Arts in Psychotherapy*, [online] 26(4), pp. 247-259. doi 10.1016/S0197-4556(98)00076-8 [accessed 12/12/2011]

MEEKUMS, B. 2000. *Creative group therapy for women survivors of child sexual abuse: Speaking the unspeakable*. London: Jessica Kingsley.

MEEKUMS, B. 2010. Moving Towards Evidence for Dance Movement Therapy: Robin Hood in Dialogue with the King. *The Arts in Psychotherapy*. [online] 37(2), pp. 35-41. doi 10.1016/j.aip.2009.10.001 [accessed 2/4/2011]

MILLS, L. J., and DANILUK, J. C. 2002. Her body speaks: The experience of dance therapy for women survivors of child sexual abuse. *Journal of Counselling & Development*, [online] 80(1), pp. 77-85. 10.1002/j.1556-6678.2002.tb00169.x [accessed 8/4/2011]

MOUSTAKAS, C. 1990. *Heuristic Research: Design, Methodology and applications*. California: SAGE Publications Inc.

MULKEY, M. 2004. Recreating masculinity: Drama therapy with male survivors of sexual assault. *The Arts in Psychotherapy*, [online] 31(1), pp. 19-28. 10.1016/j.aip.2003.11.003 [accessed 5/6/2017]

MUSICANT, S. 1994. Authentic movement and dance therapy. *American Journal of Dance Therapy* 16: 91. Pp. 25-37

NAFF, K. 2014. A framework for treating cumulative trauma with art therapy. *Art Therapy*, [online] 31(2), pp. 79-86. 10.1080/07421656.2014.903824 [accessed 14/3/2015]

NIJENHUIS, E. R. S., VAN DER HART, O, KRUGER, K., and STEELE, K. 2004. Somatoform dissociation, reported abuse and animal defence-like reactions. *The Australian and New Zealand Journal of Psychiatry*, [online] 38(9), pp. 678-686. doi 7421656.2014.903824 [accessed 30/7/2017]

NORGATE, K. 2012. EMDR for post-traumatic stress and other psychological trauma. *Nursing Times*, [online] 108, pp. 24-6. doi 23243806 [accessed 1/7/2017]

NOVY, C. 2010. The Narratives of Change project: dramatherapy and women in conflict with the law. In: JONES, P. (Ed). *Drama as therapy Volume 2: Clinical work and research into practice.* UK/USA: Routledge. Pp. 67-83

NUTTALL, J. 2006. Researching psychotherapy integration: A heuristic approach. *Counselling Psychology Quarterly*, [online] 19(4), pp. 429-444. 10.1080/09515070601090121 [accessed 3/1/2012]

OGDEN, P. 2000. Sensorimotor Psychotherapy: One Method for Processing Traumatic Memory. *Traumatology,* [online] Vol. VI, Issue 3. Pp. 161-178. doi10.1080/10481885.2012.719451 [accessed 14/2/2016]

OGDEN, P. and FISHER, J. 2014. *Sensorimotor Psychotherapy: Interventions for Trauma and Attachment*. NY: Norton Series on Interpersonal Neurobiology

OGDEN, P., MINTON, K., and PAIN, C. 2006. *Trauma and the body: A sensorimotor approach to psychotherapy*. New York, NY, US: W W Norton & Co.

O'KEARNEY, R. and PERROTT. K. 2006. Trauma narratives in posttraumatic stress disorder: A review. *Journal of traumatic stress* [online] 19 (1), pp. 81-93. doi10.1002/jts.20099 [accessed 1/8/2017]

PALM, K. M., and FOLLETTE, V. M. 2011. The roles of cognitive flexibility and experiential avoidance in explaining psychological distress in survivors of interpersonal victimization. *Journal of Psychopathology and Behavioural Assessment,* [online] 33(1), pp.79-86. 10.1007/s10862-010-9201-x [accessed 10/5/2017]

PALLARO, P. 2007. Somatic Countertransference: The Therapist in Relationship. In: PALLARO, P. (Ed) *Authentic Movement: moving the Body, Moving the Self, being Moved. A collection of essays. Vol.2*. London: Jessica Kingsley Publishers. Pp. 176-193

PANHOFER, H. and PAYNE, H., 2011. Languaging the embodied experience. *Body, Movement and Dance in Psychotherapy*. 6 (3), pp. 215-232. doi 10.1080/17432979.2011.572625 [accessed 11/5/2011]

PARKER, C., DOCTOR, R.M. and SELVAM, R., 2008. Somatic therapy treatment effects with tsunami survivors. *Traumatology,* [online] 14(3), pp. 103-109. doi doi.org/10.1177/1534765608319080 [accessed 2/11/2014]

PARKER LEWIS, P., 2007. Authentic movement as active imagination. In: PALLARO, P. (Ed). *Authentic movement: Moving the body, moving the self, being moved: A collection of essays - volume two*. GB: Jessica Kingsley Publishers. Pp. 74-79

PAYNE, P. LEVINE, P., and CRANE-GODREAU. M., 2015. Somatic experiencing: using interoception and proprioception as core elements of trauma therapy. *Frontier Psychology*; [online] 6(93), pp. 247-259. doi.org/10.3389/fpsyg.2015.00093 [accessed 3/2/2018]

PAYNE, H., WARNECKE, T., KARKOU, V., and WESTLAND, G., 2016. A comparative analysis of body psychotherapy and dance movement psychotherapy from a European perspective. *Body, Movement and Dance in Psychotherapy*, [online] 11(2-3), pp. 144-166. 10.1080/17432979.2016.1165291 [accessed 20/1/2017]

PELEG, M., LEV-WIESEL, R., and YANIV, D., 2014. Reconstruction of self-identity of holocaust child survivors who participated in 'Testimony Theatre'. *Psychological Trauma: Theory, Research, Practice, and Policy*, [online] 6(4), pp. 411-419. 10.1037/a0033834 [accessed 31/1/2015]

PERES, J. F. P., MCFARLANE, A., NASELLO, A. G., and MOORES, K. A., 2008. Traumatic memories: Bridging the gap between functional neuroimaging and psychotherapy. *Australian and New Zealand Journal of Psychiatry*, [online] 42(6), pp. 478-488. doi 10.1080/00048670802050561 [accessed 10/11/2014]

PEARLMAN, L.A. and SAAKVITNE, K.W., 1995 *Trauma and the Therapist: Countertransference and Vicarious Traumatization in Psychotherapy with Incest Survivors.* NY: W.W Norton & Company

PIERCE, L., 2014. The integrative power of Dance/Movement Therapy: Implications for the Treatment of Dissociation and Developmental Trauma. *The Arts in Psychotherapy,* [online] 41(1), pp.7-15. 10.1016/j.aip.2013.10.002 [accessed 3/12/2014]

PIQUERAS-RAMOS, I., 2015. Dance Movement Psychotherapy and sexually harmful behaviour. *Body, Movement and Dance in Psychotherapy.* [online] 11(1), pp. 60-74. 10.1080/17432979.2015.1117527 [accessed 5/8/2015]

PLATT, M. G., and FREYD, J. J., 2015. Betray my trust, shame on me: Shame, dissociation, fear, and betrayal trauma. *Psychological Trauma: Theory, Research, Practice, and Policy.* [online] 51(3), pp. 117-229. doi10.1037/tra0000022 [accessed 3/3/2016]

PORGES, S. W. 2011. *The Polyvagal Theory: Neurophysiological Foundations of Emotions, Attachment, Communication, and Self-regulation.* New York: WW Norton

PORTER, S., BIRT, A., YUILLE, J. & HERVE, H. F., 2001. Memory for murder: A psychological perspective on dissociative amnesia in legal contexts. *International Journal of Law Psychiatry*. [online] 24(1), pp. 23-42. doi.org/10.1016/S0160-2527(00)00066-2 [accessed 20/7/2017]

PORTER, S., and PEACE, K. A., 2007. Research article: The scars of memory: A prospective, longitudinal investigation of the consistency of traumatic and positive emotional memories in adulthood. *Psychological Science*, [online] 18(5), pp. 435-452. 10.1111/j.1467-9280.2007.01918.x [accessed 2/10/2014]

PRATHER, W., and GOLDEN, J. A., 2009. A behavioural perspective of childhood trauma and attachment issues: Toward alternative treatment approaches for children with a history of abuse. *International Journal of Behavioural Consultation & Therapy*, *5*(2), pp. 222-241.

PRETORIOUS, G., and PFEIFER, N., 2010. Group art therapy with sexually abused girls. *South African Journal of Psychology*, [online] 40(1), pp. 63-73. doi 10.1177/008124631004000107 [accessed 2/3/2015]

PYBIS, J., SAXON, D., HILL, A. and BARKHAM, M., 2017. The comparative effectiveness and efficiency of cognitive behaviour therapy and generic counselling in the treatment of depression: evidence from the 2nd UK National Audit of psychological therapies. *BMC Psychiatry*, [online] Vol. 17, pp. 215- 234. doi.org/10.1186/s12888-017-1370-7 [accessed 1/9/2017]

RENNIE, D. L., 2012. Qualitative research as methodical hermeneutics. *Psychological Methods*, [online] 17(3), pp. 385-398. doi 10.1037/a0029250 [accessed 4/12/2014]

REICH, W., 1942. *The function of the orgasm. The discovery of the organ*. NY: Argonne Institute press.

REICH, W., 1949. *Character analysis* (T. P. Wolfe Trans.) (3rd enlarged ed.). New York, NY: Argonne Institute press.

RICOEUR, P., 1981. *Essays on biblical interpretation* (British. ed.) London: SPCK.

RICHARDS, D. A. and BOWER, P., 2011 Equity of access to psychological therapies, *British Journal of Psychiatry*. Cambridge University Press, 198(2), pp. 91–93.

RICHARDS, L., 2005. *Handling Qualitative Data: A Practical Guide*. London: SAGE Publications Inc.

ROGERS, C.R., 1962. *On becoming a man: A therapist's view of psychotherapy.* UK: Constable & Company Ltd

ROTHBAUM, B. O., ASTIN, M. C., and MARSTELLER, F., 2005. Prolonged exposure versus eye movement desensitization and reprocessing (EMDR) for PTSD rape victims. *Journal of Traumatic Stress*, [online] 18(6), pp. 607-616. doi10.1002/jts.20069 [accessed 18/3/2015]

ROTHSCHILD, B., 2000. *The Body remembers: The Psychophysiology of Trauma and Trauma Treatment*. New York: W.W. Norton and company

ROWAN, J., and JACOBS, M., 2002. *The therapist's use of self*. Buckingham: Open University Press.

SCHACHTEL, E., 1947. *On memory and childhood amnesia*. 1st ed. Indianapolis.: Bobbs-Merrill, College Division.

SCHORE, A., 2013. Relational trauma, brain development, and dissociation. In: FORD, J. and COURTOIS, C. (Eds.), *Treating complex traumatic stress disorders in adolescents and children*. New York: Guilford Press. Pp. 178-203

SCHWEITZER, R. D., VROMANS, L., RANKE, G., and GRIFFIN, J., 2014. Narratives of healing: A case study of a young Liberian refugee settled in Australia. *The Arts in Psychotherapy*, [online] 41(1), pp. 98-106. doi10.1016/j.aip.2013.10.006 [accessed 2/3/2015]

SHALEV, A. Y., 2007. Teaching psychotherapy to psychiatric residents in Israel. *The Israel Journal of Psychiatry and Related Sciences*, 44(3), pp. 167-182

SHAPIRO, F., 2001. *Eye movement desensitization and reprocessing: Basic principles, protocols, and procedures* (2nd ed.). New York; London: Guilford Press.

SHAPIRO, F., and MAXFEILD, L., 2002. Eye movement desensitization and reprocessing (EMDR): Information processing in the treatment of trauma. *Journal of Clinical Psychology*, [online] 58(8), pp. 933-946. 10.1002/jclp.10068 [accessed 10/5/2017]

SHAW, R. L., 2015. The future is bright: Celebrating its achievements and preparing for the challenges ahead in IPA research. *Health Psychology Review,* [online] *5*(1), pp. 33-43. doi.org/10.1080/17437199.2010.524808 [accessed 1/8/2016]

SHEERIN, C. M., LIND, M. J., BOUNTRESS, K. E., NUGENT, N. R., and AMSTADTER, A. B. ,2017. The genetics and epigenetics of PTSD: Overview, recent advances, and future directions. *Current Opinions Psychology*. [online] Vol. 14, pp. 5-11. doi.org/10.1016/j.copsyc.2016.09.003 [accessed 19/12/2016]

SIEGEL, D. J., 2003. An Interpersonal Neurobiology of Psychotherapy: The Developing Mind and the Resolution of Trauma. In: SOLOMON, M. F. and SIEGEL, D. J. *Healing Trauma: Attachment, Mind, Body and Brain*. NY: W.W. Norton and Company. Pp. 1-56.

SLOAN, A. and BOWE, B., 2014. Phenomenology and hermeneutic phenomenology: The philosophy, the methodologies, and using hermeneutic phenomenology to investigate lecturers' experiences of curriculum design. *Quality & Quantity,* [online] 48 (3), pp. 1303-1303. doi10.1007/s11135-013-9835-3 [accessed 14/12/2014]

SMITH, J. A., FLOWERS, P. and LARKIN, M., 2009. *Interpretative phenomenological analysis: Theory, method and research*. London: SAGE.

SMITH, J. A., 2011. Evaluating the contribution of interpretative phenomenological analysis. *Health Psychology Review,* [online] 5(1), pp.27-40. doi 10.1080/17437199.2010.541743 [accessed 12/11/2014]

SPATES, C., KOCH, E., CUSACK, K., PAGOTO, S. and WALLER, S., 2009. Eye movement desensitization and reprocessing. In: FOA, E., KEANEK, T., FREIDMAN, M. and COHEN, J. (Eds). *Effective treatments for PTSD: practice guidelines from the international society for traumatic stress studies*. NY: Guilford Publications. Pp. 279-305

STANEK, D., 2014. Bridging past and present: Embodied intergenerational trauma and the implications for Dance Movement therapy. *Body, Movement and Dance in Psychotherapy.* [online] 10:2, pp. 94-105. 10.1080/17432979.2014.971872 [accessed 17/9/2015]

STARK-SMITH, N., 2017. A certain kind of knowing. *Contact Quarterly, 42*(2), pp. 30-33.

STANTON-JONES, K., 1992. *An Introduction to Dance Movement Therapy in Psychiatry.* USA: Routledge

STEINER, C., MUNDER, T., RABUNG, S., HOYER, J. and LEICHSENRING, F., 2017. Psychodynamic Therapy: As Efficacious as Other Empirically Supported Treatments? A Meta-Analysis Testing Equivalence of Outcomes. *American Journal of Psychiatry*. [online] 174(10), pp. 943-953. doi10.1176/appi.ajp.2017.17010057 [accessed 14/5/2018]

STROMSTED, T., 2001. Re-inhabiting the female body: Authentic movement as a gateway to transformation. *The Arts in Psychotherapy*, [online] 28(1), pp. 39-55. doi 10.1016/S0197-4556(00)00090-3 [accessed 3/5/2011]

STROMSTED, T., 2007. The dancing body in psychotherapy: Reflections on somatic psychotherapy and authentic movement. In: PALLARO, P. (Ed). *Authentic movement: Moving the body, moving the self, being moved: A collection of essays - volume two*. GB: Jessica Kingsley Publishers. Pp.202-220

STROMSTED, T., 2009. Authentic movement: A dance with the divine. *Body, Movement and Dance in Psychotherapy*, [online] *4*(3), pp. doi201-213. 10.1080/17432970902913942 [accessed 3/12/2014]

SUTTON, J, and DE BACKER, J., 2009. Music, trauma and silence: The state of the art. *The Arts in Psychotherapy*, [online] 36(2), pp. 75-83. doi10.1016/j.aip.2009.01.009 [accessed 10/2/2011]

TALWAR, S., 2007. Accessing traumatic memory through art making: An art therapy trauma protocol (ATTP). *The Arts in Psychotherapy*, [online] 34(1), pp. 22-35. 10.1016/j.aip.2006.09.001 [accessed 8/4/2017]

TEDDILE, C. and TASHAKKORI, A., 2009. *Foundations of Mixed Methods Research: Integrating Quantitative and Qualitative Approaches in the social and Behavioural Sciences*. California: sage Publications Inc.

THE EUROPEAN ASSOCIATION OF DANCE MOVEMENT THERAPY., 2017. *What is Dance Movement Therapy?* [available online] www.eadmt.com

TURNER. V. 1977. *The ritual Process: Structure and Anti-Structure.* NY: Cornell University Press

VAN DER KOLK, B.A. 2003. Posttraumatic Stress Disorder and the Nature of Trauma. In: SOLOMON, M. F. and SIEGEL, D. J. *Healing Trauma: Attachment, Mind, Body and Brain*. NY: W.W. Norton and Company, pp. 168-195.

VAN DER KOLK, B., A. 2015. *The body keeps the score: Mind, brain and body in the transformation of trauma*. UK: Penguin Books.

VAN DER KOLK, B. and MCFARLANE, A., 2007. The black hole of trauma. In: VAN DER KOLK, B., MCFARLANE, A. & WEISAETH, L. (Eds). *Traumatic stress: the effects of overwhelming experience on Mind, Body and Society*. 2ND edition. NY: The Gilford Press. Pp. 3-23.

VAN DER KOLK, B. and VAN DER HART, O., 1995. The intrusive past: The flexibility of memory and the engraving of trauma. In: CARUTH, C. (Ed) *Trauma: Explorations in Memory.* Baltimore, MD, US: Johns Hopkins University Press. Pp. 158-182

VAN DER KOLK, .B , WEISAETH, L., and VAN DER HART, O., 2007. History of trauma in psychiatry. In: VAN DER KOLK, B., MCFARLANE, A. and WEISAETH, L. (Eds). *Traumatic stress: the effects of overwhelming experience on Mind, Body and Society*. 2ND edition. New York, NY, US: Guilford Press. Pp.47-74

VAN GENNEP, A., 1960. *The rites of Passage*. Translated by: VISEDOM, M. and CAFFEE, G. London: Routledge and Kegan Paul

VAN MANAN, M., 2016. *Researching Lived Experience, Second Edition: Human Science for an Action Sensitive Pedagogy*. 2nd Edition. NY: Routledge

VAN WESTRHENEN, N., and FRITZ, E., 2014. Creative arts therapy as treatment for child trauma: An overview. *The Arts in Psychotherapy*, [online] 41(5), pp.527-534. doi 10.1016/j.aip.2014.10.004 [accessed 12/12/2014]

VAN WESTRHENEN, N., FRITZ, E., OOSTHUIZEN, H., LEMONT, S., VERMEER, A., and KLEBER, R. J., 2017. Creative arts in psychotherapy treatment protocol for children after trauma. *The arts in Psychotherapy*. [online] Vol. 54, Pp 128-135. /doi.org/10.1016/j.aip.2017.04.013 [accessed 15/9/2017]

VINCENT, F., JENKINS, H., LARKIN, M., and CLOHESSY, S., 2013. Asylum-seekers' experiences of trauma-focused cognitive behaviour therapy for post-traumatic stress disorder: A qualitative study. *Behavioural and Cognitive Psychotherapy*, [online] 41(5), pp.579-593. doi10.1017/S1352465812000550 [accessed 9/7/2015]

WALSH, D., and DOWNE, S., 2005. Meta-synthesis method for qualitative research: A literature review. *Journal of Advanced Nursing*, [online] 50(2), pp. 204-211. doi 10.1111/j.1365-2648.2005.03380.x [accessed 27/5/2015]

WEATHERS, F., KEANE, T. and FOA, E., 2009. Assessment and Diagnosis of Adults. In: FOA, E., KEANE, T., FRIEDMAN, M. and COHEN, J. (Eds). Effective treatment for PTSD: Practice

guidelines from the international society for traumatic stress studies. NY: The Guilford Press. Pp.23-61

WELLE, S., 2009. Phenomenologies of the nothing: Democritus, Heidegger, Beckett. London: Continuum

WESTLAND, G., 2015. *Verbal & Non-Verbal Communication in Psychotherapy*. USA: W.W. Norton & Companey Inc.

WIGRAM, T., NYGAARD, I. and BONDE L. 2002. *A Comprehensive Guide to Music Therapy: Theory, Clinical Practice, Research and Training.* London: Jessica Kennedy Publishers

WHITE, M., 2007. *Maps of narrative practice.* USA: W.W. Norton & Company

WINNICOTT, D. W., 1971. *Playing and reality*. London: Tavistock Publications

YARDLEY, L., 2000. Dilemmas in qualitative health research. *Psychology & Health*, [online] 15(2), pp.215-228. 10.1080/08870440008400302 [accessed 3/12/2014]

YOUNG, C., 2011. The history and development of body psychotherapy: European collaboration. *Body, Movement and Dance in Psychotherapy, 6*(1), pp. 57-68.

9 Appendices

A. Video appendix – Creative synthesis/Immersive performance: Moving through the therapeutic landscape (see attached USB)

B. Information sheet

Research description – information for participants

Research title (Provisional)

Body/creative psychotherapies and trauma: identifying therapeutic factors for the treatment of posttraumatic symptoms

My name is Caroline Galon, I am a registered Dance Movement Psychotherapist (RDMT-UK) and a Graduate Teaching Assistant (GTA)/PhD student at Edge Hill University, Ormskirk, United kingdom. Thank you for considering taking part in my research.

Research summery and aims:

This research aims to identify therapeutic factors in order to construct a trauma-focused body/creative protocol for the treatment of sufferers of posttraumatic symptoms. Trauma-focused psychotherapy aims to support a person in their post-trauma rehabilitation process, including better management of posttraumatic symptoms. Both the creative/expressive therapies and Body Psychotherapies (BP) aim to incorporate non-verbal, creative tools in a holistic approach with a view for an integrated therapeutic process. We know that incorporating body and creative clinical work in psychotherapy is very helpful for the treatment of survivors of trauma who suffer from posttraumatic symptoms. However, this understanding is currently not evidence-based and there is a professional need to further articulate the 'what's and the 'how's of creative/body work in relation to trauma. This research aims to identify key therapeutic components used for trauma work in the creative/expressive therapies and BP, link ideas and insights from different disciplines and incorporate those into a transferable and adaptable framework, specifically designed for treating survivors of trauma.

What does participation in the research entails?

You will be invited to take part in a one-hour-long interview, conducted via Skype/Collaborate and at a pre-agreed time and date. The interview will be recorded and transcribed. The data will be kept securely in Edge Hill University facilities either physically locked away in Edge Hill University facilities or electronically encrypted. Once analysis is completed and findings are fully established, the interview recordings will be securely archived in Edge Hill University. Anonymity will be maintained throughout and the transcripts will not include any details which may serve for personal identification in any shape

or form. During the analysis stage I will contact you again and ask you to comment on the identified themes.

Participants' Rights

You have the right to not answer questions during the interview without having to provide an explanation. You are free to stop the interview at any point. You can withdraw your data up to four weeks following the interview, by sending me a request for withdrawal via email (contact details below) which I will confirm via a reply email.

What will the interview be about?

During the interview you will be asked about the following topics:

- Your experience of treating survivors of trauma who suffer from posttraumatic symptoms
- The therapeutic process in the context of treating sufferers of posttraumatic symptom sufferers (SPS)
- Your experience of positive and negative change with SPS
- The therapeutic factors you experience as helpful for the treatment of SPS
- Which means support you while treating SPS

Eligibility to participate in the research:

For ethical considerations (see below – risks and benefits), you need to be attending regular clinical supervision and/or personal therapy.

In order to participate in the research you are asked to sign and returned the attached consent form via email.

Risks and benefits

Due to the distressing nature of traumatic material, which will be discussed in the interview, attending regular clinical supervision and/or personal therapy is required as a precaution for maintaining your well-being. I advise you will be meeting your supervisor/personal therapist shortly after the interview will take place, to process any reactions and responses that may result from discussing trauma related clinical material.

By participating in this research you will be contributing to the enhancement of current practice; there is a pressing need to better understand and articulate the therapeutic process in the context of trauma, for the benefits of prospective clients and novice practitioners.

Thank you very much for taking the time to read this.

If you have any further questions please do not hesitate to contact me. If you agree to be interviewed and contribute from your valuable experience to this research project, please sign the attached consent form and return it to me via email.

Contact details of the researcher:

Name: Caroline Galon MSc RDMT

Email address: galonc@edgehill.ac.uk

Address: Department of Performing Arts

Edge Hill University, Saint Helens Road, Ormskirk, Lancashire L39 4QP

Phone number: 00 44 1695 575171

C. Consent form

Participant consent form

Please tick Yes or No for the following statements:

	Yes	No
1. I confirm that I have read and understood the information sheet attached and have had the opportunity to ask questions		
2. I give consent to the researcher, Caroline Galon, to make a video/audio recording followed by a transcription, of the interview		
3. I confirm I understand I have the right to not answer specific questions during my interview, without having to provide an explanation		
4. I confirm I understand I have the right to stop the interview at any point, without having to provide an explanation.		
5. I confirm I understand I can withdraw my consent up to 4 weeks following the interview without enduring any negative consequences		
6. I give consent to the researcher, Caroline Galon, to use any/all of the data as well as disguised extracts gathered during my interview, as part of her PhD final thesis and for any subsequent publications.		
7. I confirm I understand that maintaining anonymity throughout the project, according to professional and academic ethical-research policies, means all identifying details will be omitted and/or disguised. This will be in relation to the data as well as the findings.		
8. I confirm I understand anonymity will be strictly adhered to in the researcher's final PhD thesis and any subsequent publications		
9. I confirm I attend regular clinical supervision and/or personal therapy		

Name of Participant _____

Profession / professional registration_____

Length of trauma-related clinical experience (number of years) _____

Participant contact details

_____

_____

Signature _____ Date _____

Thank you very much!

Contact details of the researcher:

Name: Caroline Galon MSc RDMT

Email address: galonc@edgehill.ac.uk

Address: Department of Performing Arts

Edge Hill University, Saint Helens Road, Ormskirk, Lancashire L39 4QP

Phone number: 00 44 1695 575171

D. Interview – Debrief

Interview Debrief Form

Thank you for participating in the interview.

This research aims to construct a body/movement oriented protocol for the treatment of posttraumatic symptoms, through the identification of therapeutic components. In the interview, you were asked about your trauma-related clinical experience and of your understanding and perception of the therapeutic process in this context. You were also asked about interventions/frameworks and therapeutic factors which supports the facilitation of positive change.

Your experience and perception are valuable to this investigation of the therapeutic process, and will serve for greater understanding of useful therapeutic factors in the context of trauma. My aim is that the findings from the interview will be used to support the creation of a transferable, clinical, trauma-focused protocol which will be useful across the somatic therapies.

Please remember that you can withdraw all data related to your interview up to four weeks following your interview by contacting me. Contact details are below.

I will contact you again over the next couple of months and ask you to comment on the identified themes.

All data collected are for research purposes only and will be used and presented in a PhD thesis as well as subsequent publications. No identifying information will be associated with the data, and the data will be coded to ensure that confidentiality and anonymity are kept at all times.

Many thanks for your participation. I greatly appreciate your taking the time to support this research.

Please do not hesitate to contact me if you have any queries.

Best wishes

Caroline Galon MSc RDMT

Email address: galonc@edgehill.ac.uk

Address: Department of Performing Arts

Edge Hill University, Saint Helens Road, Ormskirk, Lancashire L39 4QP

Phone number: 00 44 1695 575171

E. Interview Schedule

Provisional interview schedule

(The schedule will be subject to a pilot test followed by revisions when deemed necessary)

Date:

Name:

Profession/ Professional registration:

Age:

M/F

Country of residence:

Years since qualification (as a therapist):

Questions

1. Tell me about your experience of treating clients with posttraumatic symptoms?

Prompts:

How long have you been working with this client group?

What was the context of the trauma? (Physical assault, natural disasters etc)

What are the common posttraumatic symptoms your clients display?

What was the setting of the work (hospital, private practice etc)?

2. Could you describe a typical therapy session with a group/individual posttraumatic symptom sufferers?

Prompts:

What structure do you use? Why this particular one?

What type of interventions do you use? Why these interventions?

How did you develop these structures and interventions?

(What, do you find, tends to work well? What doesn't work quite as well?)

3. What is your experience of therapeutic/positive change with survivors of trauma?

Prompts:

How do you identify positive change? can you give me an example?

What makes a positive change last? can you give me an example?

What factors hinder change / make change more difficult to accomplish? Can you give me an example?

4. As a therapist, what is your contribution to enable the client's positive change?

Prompts:

How do you set up the therapeutic relationship? Can you give me an example?

How do you maintain the therapeutic process?

How do you ensure the continuation of the therapeutic process? can you give me an example?

What is most challenging in maintaining the therapeutic process?

5. What will be the important landmarks/stages clients go though during the process?

Prompts:

What will be important in the beginning of the therapy? and in the middle? and towards the end?

How do you facilitate these?

Which are most challenging to facilitate?

Can you give me some examples of these landmarks in 'real life' clinical situations?

6. In your experience, what a therapist should avoid when working with survivors of trauma?

Prompts:

Why this particular approach (etc)?

How does this approach interfere with the process? Can you give me an example?

7. In your work with posttraumatic symptom sufferers, what methods do you use to process your own reactions/responses to the trauma-related clinical material?

Prompt:

How do you recognize when you experience counter-transference responses?

How do you manage to not ‘take work home’ with you? What means do you use (reflective journal, art work directly after the session?)

Can you give an example of being overwhelmed by clinical material and how did you manage to overcome it?

8. I am now discussing the topic of trauma work with practitioners from different backgrounds. Some say that creative-expressive / body oriented approaches are good in theory but are very challenging in practice with this client group, and some say that these approaches are not as effective as cognitive/verbal therapies. What is your view on this?

9. To conclude, in your opinion, what is it in particular that your discipline/s has to offer to trauma-work?

Prompts:

What makes your discipline most helpful?

What distinguish your discipline from other forms of trauma work?

F. Example analysis of an interview

Emergent themes	Original transcript	Exploratory comments
Self as a versatile practitioner Self as a trauma focused practitioner Self as organized	A: hmm, I have several therapy trainings, my first training was in music therapy, and then dance movement therapy, and then after that I have been studying trauma psychotherapy, first three years and now this is the fourth years to become a trainer in trauma psychotherapy.	Diverse experience – different modality? A diverse practitioner? Trauma focused training – an expert?
Self as having an experience with diverse trauma populations Attachment/childhood trauma	Q: thank you. So, from there, could you tell me a little bit about your experience with trauma work, or your work with this client group? so how long have you been training…?	Diverse clinical experience? Experience with attachment theory Early trauma – childhood Technical connection issues
Children – emotional/arousal regulation problems Aggression/withdrawal Somatic symptoms	A: ha…I have worked with different kinds of trauma since I accredited from music therapy in 1999… in the beginning I mainly worked with children and adolescents, so attachment trauma, and now I also work with adults clients, but also mainly attachment trauma that's actually the client group I mainly work with now a days, very early trauma, and different kinds of problems form early childhood and attachment relationships… can you still hear me? I think I lost… your voice? (long gap… technical difficulties)	Emotional and arousal regulation issues Social withdrawal Somatic manifestations Childhood sexual abuse Somatic dissociation
Sexual abuse – physical pain?	Q: hello? Hello (participant name) hello, I do apologize, my internet connection just broke, I	Private practice Referral from doctors – link with the medical establishment?

Bodily disconnection Private practice Link with the medical system Long term therapeutic process (years) Time as a factor to establish trust Insecure attachment reduces the capacity to trust Trust takes time to build Trust is a factor to process trauma? Professional link with hospitals Multi-disciplinary work Client cantered care system Self a private practitioner collaborating with the hospital Phase oriented treatment	do apologize for that… Hmm…yes, So, I was saying it seems that you… ye, that you worked a lot with people with the attachment trauma issues… can ask you what will be the common symptoms that, hmm, this particular client group will display? A: ahh, with children it's quite often problems with emotion regulation and arousal regulations, lots of impulsive behavior, sometimes violent behavior… with some children it's more like withdrawing from relationships, not being able to engage socially with their peer group… then of course a lots of somatic symptoms, especially with my adult clients which are mainly sexually abused in their childhood, they have lots of different kind pain in their body, sometimes they don't feel their body, and also big problems with self regulation. Q: thank you, thank you for that… so just to kind of sum up this… background section, what is the setting of the work? where do you usually work – is it private practice, a hospital… and so on? A: I work in private practice, the clients will be referred to me by medical doctors, and then I will start to work with them once or twice per week… and the therapy will last approximately 3-4 years (that's a long time) that's a long time, ye, but I kind of feel that… that's when it's really…when the problems are really based on insecure attachment, issues, it will take time for the client to… start to trust to you… to you as a therapist and then been able to	Long term therapy When the trauma ties in with insecure attachment, trust takes a long time to establish Trust is essential to enable processing and progression? Slow pace is important? Not beginning with the trauma memories – trust needs to come first? Professional ties with a local hospital Part of a multi-disciplinary team, even though is in private practice Multi-disciplinary meetings *All the professional are to be of service to the clients?* The hospital is using private practitioners, due to high demand

Stabilization Creating client's resources Better regulation of symptoms Resources can take a while to build Working with traumatic effect Verbal check in Touch base with previous session impact Mutual choice of session's focus Context of focus Combining verbal and embodied processing Stabilising- creating somatic resource Processing – on the embodied level Integrating other levels of experience – verbally Ending with an attempt to integrate what was explored – closure? Artistic exploration can be transforming the experience	start process these things, and be able to progress slow enough so they will be safe for them… as well… so we are not able to jump right into the trauma memories, and things like that Q: sure, ye. when you work with children, was that private practice as well A: Yes, that's private practice as well, but I co-operate very closely with local hospital, where there is the doctor who is responsible for the child's treatment, and we have meetings every now and then and discuss where are we and how the therapy is working… so it's quite a multi-disciplinary, work, because in hospital are psychologist, occupational therapists, social workers, who also work with for the family and for the child, Q:, so, so basically you are an external party, or external agency, but at the same time you are also part of the multidisciplinary team A: yes, yes, at the hospital they don't have enough therapist services, that's why the hospital will apply therapist services from private practice Q: that sounds very good, probably better than what we have here in the UK (ok, ok)… So in terms of the structures that you use, that you use in your work, I mean, I don't know if you use structures, but if you do,sort of say something about that? So, so… so for example, how would a session with you look like?	Phase oriented treatment – general approach? Stabilization? What does that mean/involves? Building resources Resources are meant to support self-regulation? Building resources can take a long time The resources needs to be in place before touching in with the trauma? Verbal check in Follow up from the previous session? Mutual decision of exploration focus? *Mutuality – intersubjectivity?* Mixing verbal with non-verbal/embodied interventions Stabilization phase – what does somatic resources means Processing traumatic memories on the embodied level

G. Example of clustering emergent themes into a sub-ordinate theme

Hindering factors

Inter. 1.
Most patients don't do the work (p.15)

Inter.2.
Attachment issues hinder change
Clients' coping mechanism needs to be unlearnt, or it will be a hindrance
Clients need to believe in themselves (p.14)
Some clients don't get better, for reasons unknown
The client's process is influenced by their external environment
(p.15)

Inter.3
Additional mental health issues can hinder recovery (p.9)
Therapy can be supporting vulnerability but also encouraging it, indirectly (p.10)
Some clients might not get better (p.16)

Inter.4
Ending therapy isn't always a positive sigh
(p.11)
Caregivers can straggle with the therapeutic change (p.13)
Caregivers have difficulties in their lives
Therapist being in the knowing place can prevent the client from knowing
(p.14)
Logistics issues – getting into therapy
Financial issues (p.23)
Work setting's methods can harm the process
(p.24)

Inter.6
Change can be difficult if the trauma is too embedded in the client's persona (p.10)

Regular absence if physically ill (p.13)
Connecting to the unconscious can be risky (p.25)

Inter.7
Dependence on the therapist - Major obstacle to recovery
(p.9)
Inner contradiction -
The therapist is not trustable – transference?
Lack of trust - constant challenge to the therapy
(p.11)
Clients don't trust their own regulation system (p.16)

Inter.9
Fear can hinder change (p.19)
Client may straggle to change
Client's choices may be motivated by trauma patterns
(p.22)
The traumatic event/s needs to have been finished
Financial consideration to allow the therapy (p.28)
Children's and parents goals can greatly differ (p.30)
It is harmful to encourage the client to open up too soon (p.36)

Inter.10
Imposing form of interventions/aims may be replicating the trauma (p.19)
Bringing attention to an individual in a group will close them (p.20)
Group dynamic can also be hindering (p.22)

Inter.11
Too much personal involvement can harm the process – cloud the therapist's vision (p.13)
Clients not engaging with the therapy – not turning up to sessions (p.25)
What hinders change – a mystery
Client's unforeseeable circumstances may hinder change
Cultural trauma may be difficult to resolve – circumstantial continuation
(p.26)
External circumstances can hinder change
Self criticise – practitioners who go beyond the scope of their training

Therapist can be lacking in skill/responsibility (p.27)

Inter.12

The unsettling external circumstances hindered the client's engagement with the therapeutic process (p.7,8)

Challenging external circumstances can reduce clients' engagement with the process (p.16)

Inter.13

Negative view of dance and movement by clients' environment (p.10)

Clients may not be linking their addiction habits and their negative environment

(p.14)

Relaxation isn't advisable in early stages of the treatment

Relaxation can be a trigger (p.20)

Inter.14

Some clients have bad daily habits – poor management of life

Some clients have difficult relationships in daily life – hinder PC

Clients' relationships with other health professional – sometime unhelpful

Outer relationship may be draining

Many clients' have poor physical health – hindering PC

Own limitations

Self might miss something important (p.24)

There's always to possibility for the therapist to miss something

Clients might not disclose everything, for various reasons

The therapist may not create enough space for the client to disclose (p.25)

Inter.15

Cultural differences hinder trust

Parents can prevent clients attend therapy – indefinitely

Self cannot override a parent decision (p.8)

High turnover of school staff – hindering factor

Re-experiencing attachment trauma (p.12)

Self isn't Muslim – cultural hindrance

Clients are often from a patriarch families

A father can forbid Self from working with their child indefinitely

Stigma on mental health issues – very strong in local country (p.16)

Self is activated by the clients' issues – hindrance

Countertransference – hindrance (p.21)

-burn out effect – negatively altered perception (p.27)

Inter.16

Therapist too attached to process – hindering

Therapist attached to product of therapy – hindering

Therapists are often expected to produce 'cured' clients – establishment

Measurement of change – hindering

Expectations of the form the process takes – hindering

Clients' un-realistic expectations – hindering (p.10)

Too much/too fast expectations– hindering

Clients may fear changing their environment – hindering

Clients fear being excluded after abuse disclosure- hindering

Clients may not feel able to follow their impulse due to potential social consequences - hindering (p.11)

Rushing the client – hindering (p.13)

Therapists may enforce a theory – unconsciously (p.20)

Therapist thinks they know best – hindering (p.21)

Inter.17

Some therapists neglect difficult emotions-focused on achieving change (p.18)

Age as a factor in recovery – older= more difficult to change (p.22)

Therapists should avoid looking for easy solutions Better not to offer fake/unfounded understanding without the embodied lived experience of the trauma (p.27)

H. Final sub-ordinate themes

Self (therapist) in the therapy/Assessment/ Symptoms-trauma effect/Aims/Resourcing/Trauma processing /Conceptualizing trauma /Therapeutic relationship-power relations/Positive change/Hindering factors/Interventions/Verbal means/Non-verbal-creative means/Ritual /Joy/Therapist's way of processing clinical material/Therapist's self-maintenance/Client population/Work setting orientation/Conceptualizing trauma-treatment/Conceptualization of clients/General process considerations/The therapist's role/Improvisation/Trust-Safety/Landmarks/Things might get worse before they get better/Making positive change last-off treatment maintenance/Clients' attachment to the trauma/Psychoeducation/Trauma-free

space/Training-theories-academia vs clinical/Triggers

I. Video Appendix - Movement exploration (dancing in a box) (see attached USB)

J. Heuristic inquiry – Example of a written reflection

1/4/17

"Feeling tired, lost confused. Am I running away from pain? Why is joy not accessible?

Some pools remains a mystery, unknown, dark and quite on the surface. I plunge in and hold my breath and dive, only to discover I haven't even broken the surface. Dark and silent. Untold secrets. I hear a voice inside my head. 'Impossible' it says, and trust is hard to come by. I am overcome by some future loss, the one that didn't happen yet. Is this negative anticipation or wisdom? What is lurking in the dark? Whose shadow is hiding there now? What is it I can't see?

I want to feel some joy but I'm afraid of the vulnerability that's attached to it.

The whole thing seems like such a crazy idea now – WHAT WAS I THINKING? I am a performer out of practice…

Letting go of walls and letting go of defences, and speaking out the secrets and dancing the pain and the cure. I need to undress and be naked and hold on to noting.

No more half-truths – it's time to pull all the stops… will I be protected? Can I hide behind the truth? Can I hide behind my body?

*I have a strong wish to hide away from everyone, and there's a lot of pain and sadness for me to think that that's what I want"

K. Heuristic inquiry – creative synthesis – the trauma narratives

1. Broken pieces

It started with the little things. First the way I spoke to his friends was bad, and then it was the way I didn't speak to them. My English was flawed and the way I dressed was never quite right. I didn't blame him for telling me but just tried to do better. The happiest moments were shadowed by my mistakes. So I learned to accept it and live with my imperfections and feel even luckier that he still wanted to be with me. He was so good with everything and I wasn't and he still loved me… he promised me our future together, he promised me our children, and I was in love with him. We didn't do much together, because of the money it cost, he said. So he went out and I stayed at home. I was alone most of the time, a stranger in a strange land. It was bad and I was unhappy and lost and trapped and so in love. Love can be so strange sometimes.

We moved to the city. It was spring and I found a job and slowly began to feel like myself again. Maybe he didn't like it. I remember the night he didn't come home, and the following day when his phone was switched off. And in the evening he finally came back and I was angry and we had a fight and I asked him if he still loved me and he said he didn't anymore. And everything went dark and quite inside of me. I remember the room where it happened. I remember asking him to leave so I can call my mother. When I told her he doesn't want to be with me anymore I broke down in tears. That night he tried to hold me and I was numb and unresponsive. I could not believe what happened. And it was my fault. I should never have started that fight.

I always thought my heart was smashed into a thousand pieces that night. It was beyond repair. I think he might have stayed then had I begged him to, but I didn't. I was grateful to him still, this time for setting me free. I grew a new heart from the ruins of the old one because I knew I had to, I couldn't live without a heart, without love...

It still hurts you know, even after all these years. Why? Do I want him back? No! Or maybe yes?... if I did, would I admit it? That there's a part of me that wish things would have been different? I'm ashamed in that part of me. She was weak and I pushed her and her pain away because she loved him so much even though he hurt me so badly. But it still hurts now when I touch the place where that heart once was. I never comforted her, she who might love him still, somewhere inside, ashamed and desperate. I deserted her. I thought she was gone when that heart was broken and I brushed her away along with the pieces and my faith in men's constancy. I don't believe their promises anymore. I never will unless I find

her, and finding her is my only hope to be whole again. I miss her. She might still be holding on to that heart's broken pieces, safeguarding the pain so I wouldn't have to feel it. I need to find her, she who has been protecting me from that pain all these years.

2. The kiss

It was just a kiss. Just a small kiss on the cheek.

Memory is a funny thing. Some memories get forgotten while others don't… some memories are remembered but with time become blurry around the edges, like an ice cube in a hot summer day. Some memories remain sharp and clear, a shard of broken glass at the sole of the foot - a reminder of things that left their mark… and happy memories I think are like a nice dream, hazy, full of warmth, with details that blend into each other but leave some knowing behind – love… friendship… reassurance…

This is a memory I forgot. It lay dormant for years, but once remembered, I couldn't understand how it was ever forgotten. It was just a kiss on the cheek and I remember it as if it just happened a moment ago, 25 years ago, now. I remember him leaning towards me and kissing me on the cheek. I remember me freezing on the spot, taken aback, not knowing what to do. Not knowing what I'm supposed to do. I remember him telling me I'm sweet, and the word got contaminated, as was the kiss, and the cheek. I remember me in the bathroom, washing my cheek again and again with an old bar of soap, with a big empty silence inside of me, wanting to peel off the skin where he touched me. He knew my father, so I used to say hello to him when I saw him. He was always nice to me. He took something away from me and I didn't want to give it away. It was mine, and it was sacred… and it was gone. I knew it then and there it was unwanted and wrong. Groan men shouldn't kiss 11 year old girls in empty school corridors. Even if they think they're sweet, even if just on the cheek.

I never told my parents. I know now I was lucky it was just a kiss, even though I can't feel it. I found out later he harassed other girls too. I want to save the little girl I was from that kiss. I want to snatch her away from him and push him back, use my grown up power to protect her, and to protect me. I want to cast a shield between this little girl that is I, and that man, so he can't reach, can't touch, and can't take that kiss. I want to give her back her faith in people and take away the guilt; I want her to know it is allowed to feel so much pain over a fleeting kiss. I will wrap her up in an everlasting hug and comfort her for having had to endure it, and she will forgive me for not saving or helping her. I will help her now and we will be whole again.

3. Family legacy

My grandmother survived the holocaust. She was 18 and in her final school year when Austria was taken over by Nazi Germany and her whole family ran away. Her parents fled to Israel with her younger brother, and she always told us that she stayed in Vienna because she wanted to finish her exams and join her family later. That never happened. When my mother asked her years later, 'but mum, how could your parents have left you there? Why didn't they take you with them when they knew what was coming?" all she said was "I already forgave them". (pause). When they began to gather up the Jews in Austria she ran away to Belgium, dyed her hair blond and got herself some fake papers. She always said it was her perfect Belgian accent that saved her life from that holocaust. She worked for a family who took her in, until the neighbours began to say she was a Jew and she had to go into hiding. Sometimes she had to sleep rough as the Gestapo were raiding flats in the middle of the night and sending people to concentration camps. She told us about the time the Gestapo came to her hiding flat and she felt she was being pushed by an invisible hand into a nook behind the door just as the soldiers came in to the room. They didn't see her hidden just behind the open door and left. She said it was her late grandmother who protected her and pushed her into that nook. By miracle and by luck, chance, resourcefulness and strength she survived. When the war was finally over she came to Israel, was re-united with her family, got married and settled down. There are many things she never told us, many secrets that she kept. Who knows how she survived from day to day and what was the price she had to pay? Surviving that war made her stronger and she knew herself more than most people ever will, for better or for worse.

My mother was raped two years before I was born. It was her last shift at that restaurant and it was her boss who did it. The curse of sexual abuse used to run deep in our family. I was born wrapped with infinite love - with stress and fear encoded in my cells - my mother's body holding pain in its tissues and her spirit fighting on to survive. Not just to stay alive but to live on and overcome the crimes committed against her. I learnt to be strong and lonely in my pain. I remember being very young and my mum was crying and I came up to her and wanted to hug her and she pushed me away and told me to leave her alone. So I knew that pain is not for sharing. When I asked her about it later she said "I didn't want you to have it too, I didn't want it to pass on to you". I don't know what would have happened if she would have allowed me to comfort her then – I might have grown to be a different person, or not. But she allows me to comfort her now and in her journey of healing she has somehow been healing me too. My mother says healing is possible but I don't know if I quite believe her – maybe it is I who has not yet fully healed. She says that the fear of the pain is worse than the pain itself and that true healing means going through this pain and coming out from the other side.